employee benefits handbook

2009 State of Iowa
Employee Benefits Handbook

Source: Iowa Department
of Administrative Services

Risk and Benefits Management Team

October 2008

where to find benefits information

You can access information about your State of Iowa benefits at our Web site:
www.das.hre.iowa.gov/benefits.html

Examples of the information available include:
- Links to health and dental plans
- Health plan comparisons
- Health and Dependent Care Flexible Spending Account information
- Deferred Compensation information
- Life and Long Term Disability insurance information
- Link to Employee Assistance Program (EAP) Web site
- Link to Employee Discount Program
- Link to Wellness Web site which includes information about
  - -Smoking Cessation Program
  - -Prescription Drug information
  - -Wellness activities

medical plan information

Program 3 Plus and
Deductible 3 Plus
(Wellmark BCBS)
1-800-622-0043
www.wellmark.com

Iowa Select
(Wellmark BCBS)
1-800-622-0043
www.wellmark.com

Blue Access
(Wellmark BCBS)
1-800-553-7801
www.wellmark.com

Blue Advantage
(Wellmark BCBS)
1-800-553-7801
www.wellmark.com

other benefit plan information

DENTAL
Delta Dental Plan of Iowa
Customer Service:
1-800-544-0718
Enrollment:
1-877-983-3582
www.deltadentalia.com

FLEXIBLE SPENDING ACCOUNTS
ApplicationSoftware,Inc.(ASI)
1-800-659-3035
www.asiflex.com

LIFE AND LONG TERM DISABILITY
The Hartford
Life Insurance
1-800-563-1124
Long Term Disability Insurance
1-800-752-9713
www. hartfordlife.com

EMPLOYEE ASSISTANCE PROGRAM
Employee and Family Resources (EFR)
1-800-327-4692
www.efr.org/eap

DEFERRED COMPENSATION
Retirement Investors' Club
515-281-8677
www.das.hre.iowa.gov/ric.html

WORKERS' COMPENSATION
Sedgwick CMS
1-866-342-3920
www.sedgwickcms.com

ONLINE ENROLLMENT
IowaBenefits Support Line
BenefitFocus Member Services
1-866-415-7872

EMPLOYEE DISCOUNT PROGRAM
PerkSpot
http://iowa.perkspot.com

employee benefits handbook

what's new for 2009

Health references exclude the State Police Officers' Council

This handbook contains information about your State of Iowa employee benefits.
Please keep this handbook to refer to throughout the year.

ANNUAL ENROLLMENT AND CHANGE PERIOD

The annual enrollment and change period for health plans, Flexible Spending Accounts, life insurance and Premium Conversion Plan (Pretax), will be held from October 31, 2008 through December 1, 2008.

The 2009 enrollment and change period is an open enrollment period for health insurance.

Changes will be effective January 1, 2009.

You must enroll or make changes using IowaBenefits or sign and return the appropriate enrollment forms to your Personnel Assistant no later than December 1, 2008.
(Please see your Personnel Assistant for additional enrollment materials.)

Managed Care Plans No Longer Offered

Effective January 1, 2009, the two UnitedHealthcare (UHC) managed care organization (MCO) plans will no longer be offered to the State of Iowa group. Members enrolled in UnitedHealthcare Choice HMO and UnitedHealthcare Heritage Select must make a new plan selection during this year's enrollment and change period.

After a very thorough review of the 2009 renewal proposals from our health carriers and with input from an independent consultant, the state has determined that it is no longer cost effective or necessary to offer the UHC plans. Premiums submitted by UHC for these two plans for 2009 would have been more costly for employees than they have been in the past. The employee shares for family coverage for these plans would have been $95.46 (UHC Choice) and $6.12 (UHC Heritage Select) per month. In addition, Wellmark has expanded its MCO service area network and now covers all but nine of the counties in Iowa.

If you are enrolled in one of these plans, review your options and either complete a new application or enroll online for the plan of your choice before December 1, 2008. Your new plan choice will go into effect January 1, 2009.

The two MCOs offered by Wellmark, Blue Access and Blue Advantage, have the **same** benefit design as the UHC plans. Blue Access is an open model MCO as UHC Choice HMO was and Blue Advantage is a primary care model MCO as UHC Heritage Seelct was. In the past, employees may have felt that the Wellmark MCO network was not expansive enough in some areas of the state and into other surrounding states. We invite employees to check whether their providers are under the Wellmark MCO network which has grown considerably over the last two years, including the Omaha area.

For more information about how the MCOs work and service area networks, see pages 14 and 19.

Managed Care Plan Service Area Counties

Wellmark Blue Cross Blue Shield has added 10 counties to their Blue Access and Blue Advantage Managed Care Organization (MCO) service area network. Effective January 1, 2009, the following Iowa counties will now be included in their network: Cass, Crawford, Ida, Lyon, Monona, O'Brien, Osceola, Ringgold, Sioux, and Woodbury.

In addition, members enrolled in Blue Access or Blue Advantage may now receive services from participating providers in Douglas and Sarpy counties in Nebraska as well as Children's Hospital

in Omaha. For employees in northwestern Iowa, these plans include participating facilities and providers in South Dakota. In the Quad Cities area employees may be referred to participating providers with the Genesis Health System or the Iowa Health System–Trinity.

Reminder: If you are a member of one of the managed care plans, it is your responsibility to ensure that providers you seek services from are part of the managed care network for the health plan in which you are enrolled. Services with nonparticipating providers will NOT be paid by the insurance carrier. See page 14 for more information about how MCOs work.

Please review the enclosed information about your plan options and the service areas covered by the managed care plans. See your Personnel Assistant for additional assistance.

Life Insurance Enrollment and Change Period

During the enrollment and change period, you can decrease, or apply to increase, the amount of your supplemental term life insurance coverage.

If you want **to decrease** the amount of your **supplemental life insurance** coverage, complete the *Request to Decrease Supplemental Term Life Insurance* and give the form to your Personnel Assistant. Decreases will be effective January 1, 2009.

To apply **to increase** the amount of your **supplemental term life insurance**:

- Complete a Personal Health Application and send it to The Hartford.
- Complete an *Application for Supplemental Term Life Insurance* and give it to your Personnel Assistant.

Any increases to your coverage must be approved by The Hartford before they can become effective. If approved, the increase will be effective January 1, 2009.

You can get forms on the life insurance page of the Employee Benefits Web site, or from your Personnel Assistant. Once the enrollment and change period ends, you will not be able to make any changes to the amount of your supplemental term life insurance coverage until the next enrollment and change period unless you have a qualified life event during the new plan year.

Expansion of Health and Dental Insurance Coverage for Unmarried Children Under Age 25

During the 2008 legislative session, the definition of "dependent", applicable to health and dental plans in the State of Iowa, was revised and now includes your unmarried children up to the age of 25.

Effective January 1, 2009, your unmarried children between the ages of 19 and 25 may continue to be covered on your health and dental plan even if they are not full-time students.

This means that you may enroll these children in your health plan during the October 31, 2008 to December 1, 2008 enrollment and change period. If you do not enroll them during this year's open health enrollment and change period you will have to wait until next year's open health insurance change period to enroll them on your health plan.

You may not enroll these children in your dental plan until the next open dental enrollment that is negotiated.

The only exception to those enrollment opportunities would be if there was a qualified life event that would allow them to be added to your health or dental plan during the year.

In order for these non full-time student dependents ages 19 to 25 to be eligible to be on your health and/or dental plan they must be **unmarried** and **reside in the State of Iowa**. Coverage for them will continue through the end of the year in which they turn age 25, they marry, or they cease to reside in Iowa. Once you enroll them,

you will not be able to drop their coverage until the next enrollment and change period, unless you have a qualifying event.

There will be tax consequences to you if you add these children on to your insurance plans. Because they may not qualify as tax dependents per the IRS, you will have to be taxed on the value of this non-dependent coverage. The State has determined the fair market value of dependent coverage and will include this excess value of the non-qualified dependent in your gross income. You may want to consult your tax advisor for more details.

If your dependent is a full time student there is no upper age limit and they continue to qualify as your tax dependent. If your dependent is totally and permanently disabled prior to age 25, the age restriction is waived.

Please see your Personnel Assistant for more detailed information and a *Certification of Non Full-Time Student Dependent Age 19 to 25* form.

Online Enrollment

You can enroll online through IowaBenefits, a web-based enrollment system. This system allows you to enroll for health and dental benefits and make qualifying benefit changes throughout the plan year and during the annual enrollment and change period.

You can select single or family coverage, add and remove eligible family members from your plan, and inform the insurance carrier of address and phone number changes. You will be able to make these changes to your coverage via the internet and you will no longer have to complete a paper application for most changes. You will also have the ability to print an individualized summary of your health benefit elections.

This system allows for more efficient and accurate information in both the State's payroll system and the insurance carriers' membership system. You should notice faster response time for benefit changes, including quicker turn-around time for receiving insurance ID cards.

You can visit IowaBenefits by going to http://das.hre.iowa.gov/benefits.html and clicking on the IowaBenefits logo.

Vaccines at the Pharmacy

Wellmark Blue Cross Blue Shield health plans offer you the option of receiving certain vaccines at your pharmacy. Not all pharmacies provide vaccines. Only pharmacists, certified to give vaccines, can offer this service. Also, the hours that vaccines are available may be different than the normal pharmacy operating hours. You may need a prescription from your doctor for some vaccines. You should check with your pharmacy to see if vaccines are available, the hours they are available, and if a prescription is needed.

Your cost share is different depending on where you receive the vaccine. Your health plan benefit applies if you receive the vaccine in your doctor's office. If you receive the vaccine at a pharmacy, your cost share will be equal to the preferred brand name drug cost.

For additional information, visit the DAS Wellness Prescription Drug Web site: http://das.hre.iowa.gov/wellness/prescription_drugs.html

Self Administered Specialty Drugs (Excluding Deductible 3 Plus)

Effective January 1, 2009, Wellmark is changing the way that self-administered specialty drugs are covered. Previously, self-administered specialty drugs could be administered by your doctor's office, and covered under your health insurance plan. With this change, self-administered specialty drugs will be covered under your prescription drug plan.

what's new for 2009

Wellmark has identified approximately 70 self-administered specialty drugs. A list of these drugs is available at www.wellmark.com. **If you have these drugs administered at your doctor's office, you will be responsible for the full cost of the drug.**

For more information, contact Wellmark Customer Service at 1-800-622-0043.

QuitNet Tobacco Cessation

QuitNet is a Web-based telephonic program that can help you quit using tobacco products. Through QuitNet, you can access cessation counselors that offer personal support. QuitNet also offers **free** nicotine-replacement therapy if ordered through QuitNet's Web site. For employees enrolled in a Wellmark Blue Cross Blue Shield health insurance plan, there is **no cost** to participate in QuitNet.

Additional information about QuitNet, including how to enroll, can be found on the DAS Wellness Stop Smoking Web site at http://das.her.iowa.gov/wellness/stop_smoking.html.

Dependent Eligibility Verification

The dependent eligibility verification process that began in 2007 will continue in 2009. We verify eligibility in order to confirm that all persons who are covered by a State of Iowa group health plan are eligible for coverage. This helps us to hold down costs for our employees and the taxpayers of the State.

If you are selected for eligibility verification, you will be contacted by mail at your home address. Please be sure that you reply to any requests for information in a timely manner.

Please use this enrollment and change period as an opportunity to review your benefits enrollment and ensure that all persons who are covered by your plan are eligible to be covered. In general, the State of Iowa defines eligible dependents as a spouse or unmarried child/children to age 25. Your unmarried children who are over the age of 25 are also eligible for coverage if they are a full-time student.

It is important that you are aware of this ongoing verification process, because the state will make every effort to recover money that has been spent for services provided to a person who is not eligible.

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benefits general information

Introduction to This Handbook

The Risk and Benefits Management Team of the Iowa Department of Administrative Services developed this handbook to provide you with information about your benefit options for 2009, explain the enrollment and change process, and serve as a valuable resource for information about your benefits. It's a good idea to take some time to read this handbook before completing your enrollment forms and if applicable, discuss with your family members.

This handbook is not a complete description of the State of Iowa's benefit plans. Nothing in this handbook supersedes or changes any of the terms and conditions of any plan documents, insurance policies, or other legal agreements. If the wording in this handbook contradicts any plan documents, administrative rules, insurance policies, or other legal agreements, the wording in the official documents and agreements will govern.

If you have any questions, please contact your Personnel Assistant or the appropriate vendor. You can also check our Web site for more information at: http://das.hre.iowa.gov/benefits.html.

Quick Reference

Although it's a good idea to review this entire handbook, there are a few sections that apply to different types of enrollment.

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Structuring Your Benefits

The State of Iowa recognizes that employees have different needs. That's why the State offers a benefit program that allows you to choose among a number of benefit options. You can select from these options to design the benefit plan that's right for you.

You are encouraged to carefully consider your personal situation as you evaluate your benefit choices. State of Iowa benefits include:

- Deferred Compensation
- Dental Insurance
- Employee Assistance Program
- Employee Discount Program
- Flexible Spending Accounts
- Group Life Insurance
- Health Insurance
- Long Term Disability Insurance
- Premium Conversion Program
- Sick Leave Insurance Program Upon Retirement (SLIP)
- Wellness / Smoking Cessation
- DART Unlimited Ridership Program

This handbook provides summary information about each of these programs, as well as workers' compensation.

Eligibility for Benefits

You are eligible to participate in the plans described in this handbook if:

- You are a permanent (nontemporary) employee, and
- You work at least 20 hours a week on a regular basis (30 hours a week for life and long term disability benefits).

If you have questions about your eligibility for benefits, please see your Personnel Assistant.

If you are on leave without pay for any reason, you should check with your Personnel Assistant to see what benefits you are eligible to continue and to ensure that appropriate payments are being made.

Paying for Your Insurance Benefits

PREMIUM CONVERSION PLAN (PRETAX)

The Premium Conversion Plan (Pretax) allows you to pay your share of health, dental, and supplemental life insurance while saving money on income and FICA taxes. This means that your premiums are deducted from your salary before taxes are calculated. For example: If your monthly premium for medical, dental, and life insurance is $150 a month and your tax rate is 28%, you would be saving $42 a month, or $504 a year, in taxes. You are automatically enrolled in the plan. If you do not want to participate, you must complete a *Pretax Premium Conversion Form* and submit it to your Personnel Assistant. Changes can only be made within 30 days of hire, during the enrollment and change period, or at the time of a qualified life event.

Note that participation in this program lowers your wages for Social Security purposes and excludes you from the ability to claim your insurance premiums as medical expenses on your annual income tax forms.

Employees who elect more than $30,000 in supplemental life insurance are subject to imputed income taxes.
See pages 26 and 27 for more information.

How to Enroll

(AT THE TIME OF INITIAL EMPLOYMENT)

After you have made your decisions, you should complete the appropriate forms listed in the table below. You can also enroll online for health and dental benefits through IowaBenefits. You may enroll in deferred compensation or tax sheltered annuities (if eligible) at any time.

We suggest that once you have completed all of your forms, you make a photocopy of them for your records.

Return the forms to your Personnel Assistant within the first 30 days of employment. That's it! Insurance coverage will become effective the first day of the calendar month following the date you complete one month of continuous employment. Flexible Spending Account (FSA) enrollment will become effective no later than 30 days after the properly completed form is submitted to your Personnel Assistant.

WHICH FORMS DO I NEED TO COMPLETE TO ENROLL AT THE TIME OF INITIAL EMPLOYMENT?

BENEFIT PLAN	FORMS NEEDED	
BASIC LIFE INSURANCE	Group Life Insurance Enrollment Form	Complete the form within the first 30 days of your employment. If you do not complete the form you will still be enrolled for basic life.
SUPPLEMENTAL LIFE INSURANCE	Group Life Insurance Enrollment form (for any supplemental coverage within 30 days of employment).	Depending on your bargaining status, you can enroll for up to $50,000 of supplemental (optional) coverage as long as you enroll within the first 30 days of your employment. After that point in time, you must have a qualified life event and complete the Personal Health Application and Application for Supplemental Life forms. The effective date of the additional amount will depend on approval and the timing of the approval.
DENTAL PLAN	Dental Enrollment Form if your agency has not authorized you to enroll via IowaBenefits.	Complete the form or enroll online within the first 30 days of your employment. This may be your only chance to enroll unless a special open dental enrollment is offered.
LONG TERM DISABILITY PLAN	N/A	You are automatically enrolled once you are enrolled in basic life.
MEDICAL PLAN	Medical Enrollment Form if your agency has not authorized you to enroll via IowaBenefits.	Complete the form or enroll online within the first 30 days of your employment.
PREMIUM CONVERSION PLAN (PRETAX)	Pretax Premium Conversion Program Form	You are automatically enrolled unless you request not to be within 30 days of your employment. Changes can only be made during the enrollment and change period or within 30 days of a change in family or employment status.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	State of Iowa Enrollment Agreement	You must complete the form within 30 days of your employment. Changes can only be made during the enrollment and change period or within 30 days of a change in family or employment status.
HEALTH CARE FLEXIBLE SPENDING ACCOUNT(FSA)	State of Iowa Enrollment Agreement	You must complete the form within 30 days of your employment. Changes can only be made during the enrollment and change period or within 30 days of a change in family or employment status.

How to Make Changes

(TO HEALTH INSURANCE DURING THE ENROLLMENT AND CHANGE PERIOD)

(Health references exclude the State Police Officers Council)

ABOUT THE ANNUAL HEALTH PLAN ENROLLMENT AND CHANGE PERIOD

Each year during the enrollment and change period you choose the medical plan and coverage you wish to have for the next year.

This year, the annual health plan enrollment and change period is October 31, 2008 through December 1, 2008. Changes will be effective January 1, 2009 with deductions beginning with the December 19th paycheck.

During this period, you may change your health plan as described below.

- Select any health plan offered for which you are eligible
- Enroll yourself if you previously declined health coverage
- Enroll any eligible family members who are not already covered on your health plan

You and your eligible family members may be added to the health plan regardless of any pre-existing conditions as long as you enroll during this enrollment and change period.

Dependents eligible for family coverage are:

- Your spouse
- Your domestic partner
- Your unmarried children under age 25*
- Your unmarried children who are totally and permanently disabled prior to age 25
- Your unmarried children that are full-time students regardless of their age

*Unmarried children between the ages of 19 and 25 who are not full-time students must reside in the state of Iowa. There will be tax consequences to you if these dependents do not qualify as your tax dependent. See your Personnel Assistant for more details. You may also want to contact your tax advisor.

If you wish to stay with your current plan, no action is required.

Forms Needed for Enrollment and Change Period

Enrollment Deadline is December 1, 2008.

After you have made your decisions, you should complete the appropriate forms listed in the table below. You can also enroll for health dental benefits online using IowaBenefits. If, after you have reviewed all information, you wish to stay with your current health plan and it's still offered, no form is required.

We suggest that once you have completed all of your forms, you make a photocopy of them for your records.

Return the forms to your Personnel Assistant by the December 1 deadline.

That's it! Changes will become effective January 1, 2009.

WHICH FORMS DO I NEED TO COMPLETE?

BENEFIT PLAN	FORMS NEEDED	FILE A FORM IF...
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT(FSA)	State of Iowa Enrollment Agreement	You wish to make your annual designation to participate in the plan.
HEALTH FLEXIBLE SPENDING ACCOUNT(FSA)	State of Iowa Enrollment Agreement	You wish to make your annual designation to participate in the plan.
MEDICAL PLAN	Medical Enrollment Form for the Plan of Your Choice if your agency has not authorized you to enroll via IowaBenefits.	You wish to change carriers, you are enrolling for the first time, or you wish to add eligible family members.
PRETAX PREMIUM CONVERSION PLAN	Pretax Premium Conversion Program Form	You wish to change your status. You were automatically enrolled unless you requested not to be within 30 days of your employment. Changes can only be made during the enrollment and change period or within 30 days of a change in family or employment status.
LIFE INSURANCE	Application for Supplemental Term Life Insurance (Increases only) Personal Health Application (Increases only) Request to Decrease Supplemental Term Life Insurance (Decreases only)	You want to change your coverage.

How to Make Health Insurance Changes at Other Times

NEW ENROLLMENT

New employees can enroll in single or family coverage within thirty (30) calendar days following their date of employment.

When you enroll in benefits, your benefit elections remain in effect to the end of the calendar year and you cannot make any changes until the next enrollment and change period.

You cannot make any changes until the next enrollment and change period unless you experience a qualified life event and the benefit change you request is consistent with the event. For example, a marriage is a family status change that would allow you to change from single health coverage to family coverage because acquiring a spouse is consistent with a gain in eligibility for health coverage.

CHANGES DUE TO QUALIFIED LIFE EVENTS

Qualified events are defined by Section 125 of the Internal Revenue Code, based on individual circumstances and plan eligibility. This list may not apply to every benefit plan. Please see the Life Event Matrix on the State of Iowa benefits Web site at http://das.hre.iowa.gov/benefits.html.

YOU MAY BE ABLE TO CHANGE YOUR BENEFIT ELECTIONS IF...

- You have a change in your **employment status**
- Your **spouse or dependent** has a change in their **employment status**
- You have a change in your **legal martial status**
- You have a change in the **number of your dependents**
- Your **dependent** has a change in his or her **eligibility status**
- You, your spouse, or dependent has a **change in residence**
- You, your spouse, or your dependent becomes entitled to **Medicare or Medicaid**
- You are served with a **judgement, order, or decree**
- There is a **change in cost** by your dependent care provider

SPECIAL ENROLLMENT UNDER HIPAA

Opportunities to enroll in coverage during the year – Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for health insurance is available in the following circumstances. You may enroll in the health plan within 30 days of any of the following events:

- Adoption or placement for adoption
- Birth
- Loss of other health coverage
- Marriage

Opportunities to change coverage during the year – If you are already enrolled in a health plan, HIPAA allows you to add eligible family members to your already existing health plan AND enroll in a different health plan within 30 days of the following events:

- Adoption or placement for adoption
- Birth
- Loss of other health coverage
- Marriage
- Divorce or legal separation
- Death of spouse or dependent

Other opportunities to change health plans during the year – If you are already enrolled in a health plan, the following life events allow you to enroll in a different health plan regardless of

whether you are adding eligible family members.

- Commencement of an unpaid leave of absence or FMLA leave in excess of 30 days
- Death of spouse or dependent
- Decrease in work hours from full-time (30 or more hours per week) to part-time (20-29 hours per week)
- Return from an unpaid leave of absence or FMLA leave in excess of 30 days

CHANGING YOUR COVERAGE

To change your coverage when a qualifying event occurs **you must act within 30 days of the event (60 days in the case of birth or adoption)** for the change to be accepted; otherwise, you will have to wait for the next enrollment and change period in which you are eligible to participate and have the change become effective the following January 1. You may be asked to provide documentation of the change.

BIRTH OF A CHILD

At the time of the birth of a biological child, Wellmark Blue Cross Blue Shield (BCBS) will add the newborn to an existing family health contract when information becomes available from any valid source that this birth occurred (e.g., hospital or professional claim submission, online enrollment or an enrollment form). The effective date of the enrollment will be the date of birth.

If a single contract is in effect at the time of the birth of a biological child, the employee must enroll online or submit an application form to change to a family contract within sixty (60) days following the date of birth. The effective date of the family contract will be the first day of the month in which the biological child was born. The employee's share of the family premium begins with the effective date.

If a single contract holder does not submit the application for family coverage within sixty (60) days following the birth of the biological child, the child will not be able to be added until the following enrollment and change period and benefit payments will not be retroactive to the date of birth.

medical insurance

Summary of Medical Insurance Options

Depending on your location and bargaining status, you may have several health insurance options from which to choose. You must make a decision on which plan to choose and which of your family members to cover. Your choices will include an Indemnity and Preferred Provider Organization (PPO) plan. In addition, many areas have a Managed Care Organization (MCO) option.

Check the table on **page 19** to see if there are any MCOs in your area.

Health plan choices and costs differ by bargaining unit. Please review the Summary of Health Plan Options on page 9 to find the health options that are available to you.

For full-time employees with single coverage, the State pays the full cost of the monthly premium.

THINGS TO CONSIDER WHEN CHOOSING A MEDICAL INSURANCE PLAN

- Make sure you choose a plan that serves your area.
- Check the Medical Plan Comparisons on pages 15-17 for a summary comparison of benefits.
- Review the monthly premium amounts on pages 20 and 21.
- If you are interested in additional information about any of the carriers, please see your Personnel Assistant or call the numbers on the inside front cover.
- Make sure all the dependents you list are eligible. Eligible dependents include your spouse and your unmarried children to age 25 or unlimited age if unmarried and a full-time student.
- If you or a member of your family have special medical needs, call the carriers to ask about coverage for those particular needs.
- If you want to stay with your current doctor, he or she must participate in the plan you choose.
- You can set aside pretax dollars to pay for expenses not covered by your health insurance by enrolling in the Health Flexible Spending Account. See page 33 for further details.

The plans offered to State of Iowa employees have some basic differences. It's important for you to understand those differences so that you can select the best available plan for you and your family. The following pages provide an overview of each type of plan.

MEDICAL INSURANCE TERMS TO KNOW

Coinsurance The percentage of the covered expenses you must pay.

Copayment (Copay) The amount that you must pay at the time a service is rendered. For example, some plans have a $10 copayment for each doctor's office visit.

Deductible The amount you pay each year toward your initial covered expenses before the plan begins to pay benefits. Some plans do not have a deductible, or it applies to inpatient services only.

Maximum Allowable Fee The amount that equals the lesser of the covered charge for a service or supply, or an amount that the insurance company establishes annually under its schedule for the same service or supply.

Out-of-Pocket Limit The most you would ever have to pay for covered medical expenses in a year. (These amounts are different for single and family contracts.) Once you reach the out-of-pocket limit, you will not pay for any covered expenses for the rest of the year. In some plans, pharmacy expenses and other copayments are not applied to the out-of-pocket limit.

Pre-Existing Condition Any condition for which you or an eligible dependent has received medical advice, consultation, or treatment within the six months prior to the date you first become eligible for medical benefits under this plan. (This may be offset by proof of other creditable coverage.)

SUMMARY OF HEALTH PLAN OPTIONS

	BARGAINING UNIT		
	AFSCME AFSCME JUDICIAL PPME JUDICIAL NON-CONTRACT	UE/IUP	NON-CONTRACT (NON-JUDICIAL)
INDEMNITY PLAN	Program 3 Plus	Deductible 3 Plus	Deductible 3 Plus
PPO Plan	Iowa Select	Iowa Select	Iowa Select
MCO	Any	Any	Any

How Program 3 Plus (Classic Blue-Indemnity) Works

AVAILABLE TO AFSCME, AFSCME JUDICIAL, AND PPME

Wellmark BCBS Program 3 Plus, an indemnity plan, works this way:

- For office visits, you pay a $15 office visit copayment once per date of service for the exam only. No coinsurance or deductible follows this copayment. This copayment will not be applied to the out-of-pocket limit.
- The Plan pays 80% of covered charges. You pay the rest (20%).
- For inpatient services, you pay for covered expenses until those expenses reach the deductible ($300 for single contracts or $400 for family contracts).
- All copayments, coinsurance, and deductibles **except $15 office visit copayment** are applied to the medical out-of-pocket limit ($600 single, $800 family).
- There is a separate $250/$500 out-of-pocket limit for prescription drugs. This separate out-of-pocket limit does NOT apply to the medical out-of-pocket limit.
- There are no annual or lifetime maximum benefit limits. However, certain services do have limits; for example, only one physical per year is covered.
- The pre-existing condition waiting period for new employees is 11 months. (This may be offset by proof of prior creditable coverage.)
- You may go to any licensed physician or hospital. Although the majority of health care providers do accept this type of insurance, some health care providers do not participate with Wellmark BCBS. If you go to a nonparticipating provider, you could be responsible for paying additional monies out of your pocket, as that provider has not agreed to Wellmark's payment. Anything above what Wellmark allows is your responsibility.

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefits are provided through a three-tier program. This means that you pay a copayment at the time you receive your prescription until you reach your separate prescription drug out-of-pocket limit. The amount of your copayment is determined by the drug that you receive.

Copayment amounts are:

- $5.00 for preferred generic drugs
- $15.00 for preferred brand name drugs, and
- $30.00 for non preferred brand name **and non preferred generic** drugs.

If a generic equivalent is appropriate and available and you choose a brand name drug, you are responsible for the copayment plus any difference between the maximum allowable fees for the generic and brand name drug, even if the provider has specified that the brand name drug must be taken. You will be required to pay this difference even after you have reached your separate prescription out-of-pocket limit.

MAIL ORDER PRESCRIPTION DRUGS

You can save money and have the convenience of home delivery if you use mail order for your maintenance prescription drugs. You can receive up to a 90 day supply for just two copays instead of three by using mail order. Contact your insurance carrier for the forms and steps to follow to begin ordering through the mail.

SELF-ADMINISTERED SPECIALTY DRUGS

Self-Administered Specialty Drugs are high-cost injectable, infused, oral, or inhaled drugs for the ongoing treatment of a chronic condition. They are covered by your prescription drug plan. You must get these drugs at a pharmacy or through the Caremark Specialty Pharmacy. You can contact the Caremark Specialty Pharmacy at 1-800-237-2767. You will generally pay a tier 3 copayment for these drugs. If you get a self-administered specialty drug at your doctor's office, you will have to pay for it yourself.

How Deductible 3 Plus (Classic Blue-Indemnity) Works

AVAILABLE TO UE/IUP AND NON-CONTRACT (NON-JUDICIAL) COVERED EMPLOYEES

Wellmark BCBS Deductible 3 Plus, an indemnity plan, works this way:

- You pay an annual deductible of $300 for single contracts or $400 for family contracts each plan year. This deductible applies to ALL services before insurance coverage begins.
- The Plan pays 80% of covered charges after the deductible is met for most services. You pay the rest (20%). The following services are paid at 100% after the deductible: outpatient surgery, accidents, valid emergency, and dental accident care.
- Any portion of the deductible satisfied in the last three months of the year will be credited for the following year as well.
- All copayments, coinsurance, and deductibles are applied to the out-of-pocket limit.
- Once the deductibles and coinsurance you have paid reach the out-of-pocket limit ($600 for single or $800 for family), any remaining covered medical expenses are paid by the Plan at 100%.
- There are no annual or lifetime maximum benefit limits. However, certain services do have limits; for example, only one physical per year is covered.
- The pre-existing condition waiting period for new employees is 11 months. (This may be offset by proof of prior creditable coverage).
- You may go to any licensed physician or hospital. Although the majority of health care providers do accept this type of insurance, some health care providers do not participate with Wellmark BCBS.

  If you elect to utilize a nonparticipating provider, you could be responsible for paying additional monies out of your pocket, as that provider has not agreed to Wellmark's payment. Anything above what Wellmark allows is your responsibility.

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefits are covered on a "cash and carry basis." This means that you pay the full cost of the prescription and are reimbursed for 80% of Wellmark's allowed amount after you have met your deductible. If you use a participating pharmacist, the pharmacist will file the claim for you, which will result in lower out-of-pocket costs, and a quicker turnaround for reimbursement. If you do not go to a participating pharmacy, you will have to submit a paper claim to Wellmark and will be reimbursed at 80%, after deductible, of what Wellmark would have paid to a participating pharmacy.

How Iowa Select (Alliance Select-PPO) Works

AVAILABLE TO AFSCME, AFSCME JUDICIAL, UE/IUP, PPME AND NON-CONTRACT COVERED EMPLOYEES

Iowa Select, the Wellmark BCBS Preferred Provider Organization (PPO), works similarly to Program 3 Plus, with one major difference. Iowa Select contracts with health care service providers (hospitals, doctors, etc.) for reduced fees for each type of service. These savings are passed on to you with lower coinsurance rates (10%) if you use the network providers. You may use out-of-network providers (providers who are not part of the PPO), but then you will pay a higher coinsurance rate (20%) and are subject to the deductible.

Other Iowa Select provisions include:

- For office visits, you pay a $15 office visit copayment once per date of service for the exam only. No coinsurance or deductible follows this copayment. This copayment will not be applied to the out-of-pocket limit.
- An annual deductible ($250 single; $500 family) applies to both inpatient and outpatient services.
- The deductible is waived for any services provided in the office or clinic setting of an Iowa Select physician.
- An out-of-pocket limit ($600 single; $800 family) applies to services in- and out-of-network and includes deductibles, coinsurance, and copayments, **except the $15 office visit copayment** and prescription copays or coinsurance. There is a separate out-of-pocket limit ($250 single; $500 family) for prescription drugs. This prescription out-of-pocket limit does not apply toward the medical out-of-pocket limit.
- No annual or lifetime maximum benefit limits. However, certain services do have limits; for example, only one physical per year is covered.
- The pre-existing condition waiting period for new employees is 11 months. (This may be offset by proof of prior creditable coverage.)
- If you use network providers, you do not need to submit claim forms. The provider will do that for you.
- If you do not use network providers, you are responsible for the deductible, 20% coinsurance, plus any amount above Wellmark's allowable amount.

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefits are provided through a three-tier program. This means that you pay a copayment at the time you receive your prescription until you reach your separate prescription drug out-of-pocket limit. The amount of your copayment is determined by the drug that you receive. Copayment amounts are:

- $5.00 for preferred generic drugs
- $15.00 for preferred brand name drugs, and
- $30.00 for non preferred brand name **and non preferred generic** drugs.

If a generic equivalent is appropriate and available and you choose a brand name drug, you are responsible for the copayment plus any difference between the maximum allowable fees for the generic and brand name drug, even if the provider has specified that the brand name drug must be taken. You will be required to pay this difference even after you have reached your separate prescription out-of-pocket limit.

MAIL ORDER PRESCRIPTION DRUGS

You can save money and have the convenience of home delivery if you use mail order for your maintenance prescription drugs. You can receive up to a 90 day supply for just two copays instead of three by using mail order. Contact your insurance carrier for the forms and steps to follow to begin ordering through the mail.

SELF-ADMINISTERED SPECIALTY DRUGS

Self-Administered Specialty Drugs are high-cost, injectable, infused, oral, or inhaled drugs for the ongoing treatment of a chronic condition. They are covered by your prescription drug plan. You must get these drugs at a pharmacy or through the Caremark Specialty Pharmacy. You can contact the Caremark Specialty Pharmacy at 1-800-237-2767. You will generally pay a tier 3 copayment for these drugs. If you get a self-administered specialty drug at your doctor's office, you will have to pay for it yourself.

How MCOs Work

Depending upon your location, you may have a Managed Care Organization (MCO) option. You may also have a choice in the type of MCO you can select. State of Iowa benefits currently include two types of MCO - Primary Care and Open Access. It is important that you understand the differences between the types of MCOs to ensure that you choose the plan that best fits your needs.

PRIMARY CARE MCOS

Primary Care MCOs provide services that are managed by a primary care physician (PCP). You must select a PCP for each person covered by the plan. Wellmark BCBS Blue Advantage requires that your PCP refer you to participating specialists.

OPEN ACCESS MCOS

Open Access MCOs allow you to obtain care from any provider who participates in the MCO's network. No PCP referral is required. Wellmark BCBS Blue Access is an open access MCO and allows you to go to any provider in their network at any time.

OTHER MCO PROVISIONS INCLUDE:

- No required deductibles. However, there are coinsurance and copayments that vary by service provided.
- There are no annual or lifetime maximum benefit limits. However, certain services do have limits; for example, only one physical per year may be covered.
- Emphasis on preventive services, with 100% coverage for an annual physical, well baby care, screening mammograms, and disease management programs.
- No need to fill out any claim forms.
- No pre-existing condition waiting period for new employees.
- If you receive care from an out-of-network provider, unless it is an emergency, you are responsible for full payment.

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefits are provided through a three-tier program. This means that you pay a copayment at the time you receive your prescription. The amount of your copayment is determined by the drug that you receive. Copayment amounts are:

- $5.00 for preferred generic drugs
- $15.00 for preferred brand name drugs, and
- $30.00 or 25% (whichever is higher) for non-preferred brand or generic drugs.

The prescription must be for a covered service and from a participating plan pharmacy. No ancillary charges may be assessed.

Prescription copayments do not apply to the out-of-pocket maximum.

MAIL ORDER PRESCRIPTION DRUGS

You can save money and have the convenience of home delivery if you use mail order for your maintenance prescription drugs. You can receive up to a 90 day supply for just two copays instead of three by using mail order. Contact your insurance carrier for the forms and steps to follow to begin ordering through the mail.

SELF-ADMINISTERED SPECIALTY DRUGS

Self-Administered Specialty Drugs are high-cost, injectable, infused, oral, or inhaled drugs for the ongoing treatment of a chronic condition. They are covered by your prescription drug plan. You must get these drugs at a pharmacy or through the Caremark Specialty Pharmacy. You can contact the Caremark Specialty Pharmacy at 1-800-237-2767. You will generally pay a tier 3 copayment for these drugs. If you get a self-administered specialty drug at your doctor's office, you will have to pay for it yourself.

MCOS ARE NOT AVAILABLE IN ALL AREAS. COUNTIES NOT SERVED BY A MANAGED CARE ORGANIZATION: Allamakee, Cherokee, Clay, Des Moines, Dickinson, Dubuque, Emmet, Fayette and Winneshiek

Medical Care Management Features

All of the medical plans have built in features that are meant to coordinate and manage your medical care. Managed care organization plans, for example, have a PCP who is assigned the task of managing your total medical care. All of the plans have some features that help manage your medical care so that you receive the care you need in a cost-effective manner. Some of these features include:

PREAPPROVAL OF HOSPITAL ADMISSIONS

Some plans require preapproval of your hospital admission before you go to the hospital. Of course, in an emergency, get help first and then call the plan to let them know about your hospitalization.

SECOND SURGICAL OPINIONS

In most cases, getting a second surgical opinion is voluntary. In some cases it is required. The charges for a second surgical opinion are paid according to the normal plan benefits.

LARGE CASE MANAGEMENT

In cases that require a multitude of services for a longer period of time, alternative care may be recommended.

DISEASE MANAGEMENT

If you have a chronic health condition, you may want to participate in programs offered by our health plans that are designed to help you take a more active role in managing your condition. These programs offer early detection, patient education, suggested lifestyle changes, and other support and resources for living as healthy as possible with a chronic disease.

AFSCME, AFSCME Judicial, Judicial Non-Contract, and PPME Medical Plan Comparison – What You Pay

The three types of medical plans vary in access to providers, first expenses (deductibles), out-of-pocket limits, and the portion you have to pay. For a comparison of the plans see the chart below.

SERVICE/PLAN	PROGRAM 3 PLUS	IOWA SELECT	MCO
Access to Providers	Full Access	Lower level of benefits if not in the network	Varies; see below[1]
Coinsurance Percentage	20%	10%/20%[2]	Varies by service
Deductibles Single Family	Inpatient Only $300 $400	Waived only for in-network office/clinic setting $250 $500	None
Dependent child age limit[3]	25/unlimited	25/unlimited	25/unlimited
Emergency Room Care	0%, no deductible	$50.00 copayment; waived if admitted. Copayment and co-insurance apply. Copayment applies after out-of-pocket limit is met.	$50.00 copayment; waived if admitted.
Hospital Services	20%, after deductible, if authorized	10%/20%, after deductible, if authorized	100% paid, if authorized
Lifetime Maximum	None	None	None
Mail Order Prescription Drugs	Covered as below for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Covered as below for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Up to a 90-day supply for: $10 copay (generic) $30 copay (preferred brand name) $60 copay (non-preferred brand name and non-preferred generic)
Out-of-Pocket Limits Single Family	$600 $800 All copayments, deductible, and coinsurances, **except $15 office visit copayment,** apply. Separate $250/$500 out-of-pocket limit for prescription drugs, does not apply to medical out-of-pocket limit.	$600 $800 All deductible, coinsurances, and copayments, except $15 office visit copayment, apply. ER care copayment continues to apply after out-of-pocket limit is met. Separate $250/$500 out-of-pocket limit for prescription drugs; does not apply to medical out-of-pocket limit.	$750 $1,500 All copayments, except prescription drug copayments, apply
Physicians Office Visit	$15 copayment once per date of service for exam only. No coinsurance, no deductible. 20% coinsurance, no deductible for other office services. Copayment does not apply to out-of-pocket limit.	$15 copayment once per date of service for exam only. No coinsurance, no deductible. 10% deductible waived for other office services performed in-network; 20% after deductible for other office service performed out-of-network.	$10 copay
Prescription Drugs	$5 copay (preferred generic)[4] $15 copay (preferred brand name) $30 (non-preferred brand name and non-preferred brand name and non-preferred generic)	$5 copay (preferred generic)[4] $15 copay (preferred brand name) $30 (non-preferred brand name and non-preferred generic)	$5 copay (preferred generic) $15 copay (preferred brand name) Greater of $30 or 25% (non-preferred brand name and non-preferred generic)
Routine Physicals (limit to one per year)	20%	10%/20%	$10 copay
Outpatient Mental Health	20%. Use of mental health network required.	10%/20% deductible waived in Select provider's office setting. Use of mental health network required.	$10 copayment per visit. Maximum of 52 visits per Member per calendar year.

1. Blue Access provides access to any network provider. Blue Advantage requires a primary care physician referral. 2. Network/non-network providers. 3. Age to which unmarried dependents are covered whether full-time students or not if reside in Iowa (may be tax consequences)/age to which dependents are covered if unmarried and full time students. 4. If a generic equivalent is appropriate and available and the member chooses a brand name drug, the member is responsible for the copayment plus any difference between the maximum allowable fees for the generic and brand name drug, even if the provider has specified that the brand name must be taken.

UE/IUP Medical Plan Comparison – What You Pay

The three types of medical plans vary in access to providers, first expenses (deductibles), out-of-pocket limits, and the portion you have to pay. For a comparison of the plans see the chart below.

SERVICE/PLAN	DEDUCTIBLE 3 PLUS	IOWA SELECT	MCO
Access to Providers	Full Access	Lower level of benefits if not in the network	Varies; see below[1]
Coinsurance Percentage	20%	10%/20%[2]	Varies by service
Deductibles Single Family	Applies to ALL services $300 $400	Waived only for in-network office/clinic setting $250 $500	None
Dependent child age limit[3]	25/unlimited	25/unlimited	25/unlimited
Emergency Room Care	0%, after deductible	$50.00 copayment; waived if admitted. Copayment and co-insurance apply. Copayment applies after out-of-pocket limit is met.	$50.00 copayment; waived if admitted.
Hospital Services	20%, after deductible, if authorized	10%/20%, after deductible, if authorized	100% paid, if authorized
Lifetime Maximum	None	None	None
Mail Order Prescription Drugs	Not Available	Covered as below for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Up to a 90-day supply for: $10 copay (generic) $30 copay (preferred brand name) $60 copay (non-preferred brand name and non-preferred generic)
Out-of-Pocket Limits Single Family	$600 $800 All copayments, deductible, and coinsurances apply to out-of-pocket limit	$600 $800 All deductible, coinsurances, and copayments, except $15 office visit copayment, apply. ER care copayment continues to apply after out-of-pocket limit is met. Separate $250/$500 out-of-pocket limit for prescription drugs; does not apply to medical out-of-pocket limit.	$750 $1,500 All copayments, except prescription drug copayments, apply
Physician Office Visits	20%, no deductible	$15 copayment once per date of service for exam only. No coinsurance, no deductible. 10% deductible waived for other office services performed in-network; 20% after deductible for other office service performed out-of-network.	$10 copay
Prescription Drugs	20%, after deductible	$5 copay (preferred generic)[4] $15 copay (preferred brand name) $30 (non-preferred brand name and non-preferred generic)	$5 copay (preferred generic) $15 copay (preferred brand name) Greater of $30 or 25% (non-preferred brand name and non-preferred generic)
Routine Physicals (limit to one per year)	20%, after deductible	10%/20%	$10 copay
Outpatient Mental Health	20%, after deductible. Use of mental health network required.	10%/20% deductible waived in Select provider's office setting. Use of mental health network required.	$10 copayment per visit. Maximum of 52 visits per Member per calendar year.

1. Blue Access provides access to any network provider. Blue Advantage requires a primary care physician referral. 2. Network/non-network providers. 3. Age to which unmarried dependents are covered whether full-time students or not if reside in Iowa (may be tax consequences)/age to which dependents are covered if unmarried and full time students. 4. If a generic equivalent is appropriate and available and the member chooses a brand name drug, the member is responsible for the copayment plus any difference between the maximum allowable fees for the generic and brand name drug, even if the provider has specified that the brand name must be taken.

Non-Contract (Non-Judicial) Medical Plan Comparison – What You Pay

The three types of medical plans vary in access to providers, first expenses (deductibles), out-of-pocket limits, and the portion you have to pay. For a comparison of the plans see the chart below

SERVICE/PLAN	DEDUCTIBLE 3 PLUS	IOWA SELECT	MCO
Access to Providers	Full Access	Lower level of benefits if not in the network	Varies; see below[1]
Coinsurance Percentage	20%	10%/20%[2]	Varies by service
Deductibles Single Family	Applies to ALL services $300 $400	Waived only for in-network office/clinic setting $250 $500	None
Dependent child age limit[3]	25/unlimited	25/unlimited	25/unlimited
Emergency Room Care	0%, after deductible	$50.00 copayment; waived if admitted. Copayment and co-insurance apply. Copayment applies after out-of-pocket limit is met.	$50.00 copayment; waived if admitted.
Hospital Services	20%, after deductible, if authorized	10%/20%, after deductible, if authorized	100% paid, if authorized
Lifetime Maximum	None	None	None
Mail Order Prescription Drugs	Not Available	Covered as below for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Up to a 90-day supply for: $10 copay (generic) $30 copay (preferred brand name) $60 copay (non-preferred brand name and non-preferred generic)
Out-of-Pocket Limits Single Family	$600 $800 All copayments, deductible, and coinsurances apply to out-of-pocket limit	$600 $800 All deductible, coinsurances, and copayments, except $15 office visit copayment, apply. ER care copayment continues to apply after out-of-pocket limit is met. Separate $250/$500 out-of-pocket limit for prescription drugs; does not apply to medical out-of-pocket limit.	$750 $1,500 All copayments, except prescription drug copayments, apply
Physician Office Visits	20%, no deductible	$15 copayment once per date of service for exam only. No coinsurance, no deductible. 10% deductible waived for other office services performed in-network; 20% after deductible for other office service performed out-of-network.	$10 copay
Prescription Drugs	20%, after deductible	$5 copay (preferred generic)[4] $15 copay (preferred brand name) $30 (non-preferred brand name and non-preferred generic)	$5 copay (preferred generic) $15 copay (preferred brand name) Greater of $30 or 25% (non-preferred brand name and non-preferred generic)
Routine Physicals (limit to one per year)	20%, after deductible	10%/20%	$10 copay
Outpatient Mental Health	20%, after deductible. Use of mental health network required.	10%/20%, deductible waived in Select provider's office setting. Use of mental health network required.	$10 copayment per visit. Maximum of 52 visits per Member per calendar year.

1. Blue Access provides access to any network provider. Blue Advantage requires a primary care physician referral. 2. Network/non-network providers. 3. Age to which unmarried dependents are covered whether full-time students or not if reside in Iowa (may be tax consequences)/age to which dependents are covered if unmarried and full time students. 4. If a generic equivalent is appropriate and available and the member chooses a brand name drug, the member is responsible for the copayment plus any difference between the maximum allowable fees for the generic and brand name drug, even if the provider has specified that the brand name must be taken.

medical insurance

2009 Managed Care Service Area

Wellmark BCBS has determined that the following counties have adequate participating providers to offer services as noted. Please check the provider directories to ensure that there are participating doctors, specialists, labs, hospitals, clinics, etc. in your area. **VERY IMPORTANT: Services will not be paid by the carrier if you do not go to participating providers for all your health care needs.**

County	Blue Access	Blue Advantage	County	Blue Access	Blue Advantage
Adair	X	X	Jasper	X	X
Adams	X	X	Jefferson	X	X
Allamakee			Johnson	X	X
Appanoose	X	X	Jones	X	X
Audubon	X	X	Keokuk	X	X
Benton	X	X	Kossuth	X	X
Black Hawk	X	X	Lee	X	X
Boone	X	X	Linn	X	X
Bremer	X	X	Louisa	X	X
Buchanan	X	X	Lucas	X	X
Buena Vista	X	X	Lyon	X	X
Butler	X	X	Madison	X	X
Calhoun	X	X	Mahaska	X	X
Carroll	X	X	Marion	X	X
Cass	X	X	Marshall	X	X
Cedar	X	X	Mills	X	X
Cerro Gordo	X	X	Mitchell	X	X
Cherokee			Monona	X	X
Chickasaw	X	X	Monroe	X	X
Clarke	X	X	Montgomery	X	X
Clay			Muscatine	X	X
Clayton	X	X	O'Brien	X	X
Clinton	X	X	Osceola	X	X
Crawford	X	X	Page	X	X
Dallas	X	X	Palo Alto	X	X
Davis	X	X	Plymouth	X	X
Decatur	X	X	Pocahontas	X	X
Delaware	X	X	Polk	X	X
Des Moines			Pottawattamie	X	X
Dickinson			Poweshiek	X	X
Dubuque			Ringgold	X	X
Emmet			Sac	X	X
Fayette			Scott	X	X
Floyd	X	X	Shelby	X	X
Franklin	X	X	Sioux	X	X
Fremont	X	X	Story	X	X
Greene	X	X	Tama	X	X
Grundy	X	X	Taylor	X	X
Guthrie	X	X	Union	X	X
Hamilton	X	X	Van Buren	X	X
Hancock	X	X	Wapello	X	X
Hardin	X	X	Warren	X	X
Harrison	X	X	Washington	X	X
Henry	X	X	Wayne	X	X
Howard	X	X	Webster	X	X
Humboldt	X	X	Winnebago	X	X
Ida	X	X	Winneshiek		
Iowa	X	X	Woodbury	X	X
Jackson	X	X	Worth	X	X
			Wright	X	X

Monthly Health Insurance Premiums

These rates are for active full-time employees only. If you are part-time, disabled, retired, or covered by COBRA, call your Personnel Assistant for your rates.

2009 MONTHLY HEALTH INSURANCE PREMIUMS
SINGLE COVERAGE

PLAN	Total Premium	State Pays	You Pay
Program 3 Plus (Wellmark BCBS) *(AFSCME, AFSCME Judicial, Judicial Non-Contract, PPME employees only*	$643.23	$643.23	$0.00
Deductible 3 Plus (Wellmark BCBS) *UE/IUP and Non-Contract (non-Judicial) employees only*	$646.46	$646.46	$0.00
Iowa Select PPO (Wellmark BCBS)	$640.92	$640.92	$0.00
Blue Access (Wellmark BCBS)	$398.49	$398.49	$0.00
Blue Advantage (Wellmark BCBS)	$383.30	$383.30	$0.00

2009 MONTHLY HEALTH INSURANCE PREMIUMS
FAMILY COVERAGE
AFSCME
AFSCME JUDICIAL
JUDICIAL NON-CONTRACT
PPME

PLAN	Total Premium	State Pays	You Pay
Program 3 Plus (Wellmark BCBS)	$1,505.17	$1,274.79	$230.38
Iowa Select PPO (Wellmark BCBS)	$1,499.75	$1,274.79	$224.96
Blue Access (Wellmark BCBS)	$932.47	$932.47	$0.00
Blue Advantage (Wellmark BCBS)	$896.94	$896.94	$0.00

2009 MONTHLY HEALTH INSURANCE PREMIUMS
FAMILY COVERAGE
NON-CONTRACT (NON-JUDICIAL)
UE/IUP

PLAN	Total Premium	State Pays	You Pay
Deductible 3 Plus (Wellmark BCBS)	$1,512.76	$1,274.80	$237.96
Iowa Select PPO (Wellmark BCBS)	$1,499.75	$1,274.79	$224.96
Blue Access (Wellmark BCBS)	$932.47	$932.47	$0.00
Blue Advantage (Wellmark BCBS)	$896.94	$896.94	$0.00

dental insurance

Dental Insurance

(Dental references exclude the State Police Officers Council)

For more information, call Delta Dental Plan of Iowa at 1-800-544-0718

DENTAL PROVISIONS

The dental plan pays up to $1,500 of covered expenses per person per year, as follows:

- 100% for routine check-ups and cleanings twice in a benefit period;
- 80% for routine restorative services, such as fillings;
- 50% for non-surgical and surgical periodontal treatments, root canals, and crowns (must have prior approval);
- 50% for bridges and dentures (prosthetics); and
- 50% for dependent orthodontia (unmarried dependent children under 19 only); no deductible; up to $1,500 per eligible dependent in a lifetime.

THINGS TO CONSIDER

- You can only enroll during the first 30 days of your employment.
- Dependents can only be added during your initial enrollment or as a result of a qualifying event such as marriage, birth, or adoption.
- Only those dependents directly affected by the event may be added. See the following list of qualifying events.
- Dependents eligible for family coverage are:
  - Your spouse
  - Your domestic partner
  - Your unmarried children under age 25*
  - Your unmarried children who were totally and permanently disabled prior to age 25
  - Your unmarried children that are full-time students regardless of their age

*Unmarried children between the ages of 19 and 25 that are not full-time students must reside in the State of Iowa. There will be tax consequences to you if these dependents do not qualify as your tax dependent. See your Personnel Assistant for more details. You may also want to contact your tax advisor.

- You can set aside pretax dollars to pay for expenses not covered by your dental insurance by enrolling in the Health Flexible Spending Account. See page 33 for further details.
- If you are a part-time benefits eligible employee and you change to full-time, you may enroll in the dental plan within 30 days of your change in work hours.

QUALIFYING EVENTS FOR MAKING CHANGES TO DENTAL INSURANCE

You can only make changes to your dental enrollment if you are already enrolled in the plan. In order to change your dental plan enrollment you must have one of the following qualifying events. If you are not currently enrolled in the dental plan, these events will not allow you to join the plan.

- Marriage
- Death of a spouse or dependent
- Adoption of a child, or addition of a step or foster child
- Employee or spouse reaches age 65
- Employee, spouse, or dependent becomes eligible for Medicare
- Divorce, annulment, legal separation, or dissolution of a marriage
- Dependent no longer eligible (age 19 to 25 and no longer a full-time student, dependent marries, or no longer resides in Iowa)
- Dependent resumes full-time student status
- Spouse loses coverage through another employer due to involuntary loss of employment (lay-off, discharge, business closing). (Proof of loss shall be the "Involuntary Loss of Coverage Statement" signed and dated by the previous employer.)
- Birth of a biological child: If moving from single to family, the effective date of the family contract will be the first day of the month in which the child is born. Family premiums

will begin with this effective date. If a single contract holder does not submit the application for family coverage within 60 days of the birth, there is no further opportunity to add the newborn.

A dental enrollment/change form or enrollment through IowaBenefits is always required when adding a newborn.

Monthly Dental Insurance Premiums

These rates are for active full-time employees only. If you are part-time, disabled, retired, or covered by COBRA, call your Personnel Assistant for your rates.

2009 MONTHLY DENTAL INSURANCE PREMIUMS SINGLE COVERAGE

PLAN	Total Premium	State Pays	You Pay
AFSCME	$26.14	$26.14	$0.00
AFSCME Judicial	$26.14	$26.14	$0.00
PPME	$26.14	$26.14	$0.00
Non-Contract	$26.14	$26.14	$0.00
UE/IUP	$26.14	$26.14	$0.00

2009 MONTHLY DENTAL INSURANCE PREMIUMS FAMILY COVERAGE

PLAN	Total Premium	State Pays	You Pay
AFSCME	$70.06	$35.04	$35.02
AFSCME Judicial	$70.06	$35.04	$35.02
PPME	$70.06	$35.04	$35.02
Non-Contract	$70.06	$35.04	$35.02
UE/IUP	$70.06	$26.14	$43.92

Delta Dental Plan of Iowa

Summary of Covered Services and Benefits

PRODUCT: DELTA PREMIER	DEDUCTIBLE	COINSURANCE	BENEFIT PERIOD MAX	ORTHO LIFETIME MAX
BENEFIT CATEGORIES:	None	—	$1,500	—
Check Ups and Teeth Cleaning (two visits per benefit period) (Diagnostic and Preventive Services) 1. Dental Cleaning 2. Oral Evaluations 3. Fluoride Applications 4. X-rays	—	0%	Yes	—
Cavity Repair and Tooth Extractions (Routine and Restorative Services) 1. Contour of Bone 2. Emergency Treatment 3. General Anesthesia/Sedation 4. Restoration of Decayed or Fractured Teeth 5. Limited Occlusal Adjustment 6. Routine Oral Surgery 7. Sealant Applications - $120/lifetime 8. Space Maintainers	—	20%	Yes	—
Root Canals (Endodontic Services) 1. Apicoectomy 2. Direct Pulp Cap 3. Pulpotomy 4. Retrograde Fillings 5. Root Canal Therapy	—	50%	Yes	—
Gum and Bone Diseases (Periodontal Services) 1. Conservative Procedures (Non-Surgical) 2. Complex Periodontal Procedures (Surgical) 3. Maintenance Therapy	—	50%	Yes	—
High Cost Restorations (Cast Restorations) 1. Cast Restorations a. Crowns b. Inlays c. Onlays d. Posts and Cores	—	50%	Yes	—
Bridges and Dentures (Prosthetics) 1. Bridges 2. Dentures	—	50%	Yes	—
Straighter Teeth (Orthodontics) *Only for unmarried dependent children under age 19.*	—	50%	Waive	$1,500

This is a general description of coverage. It is not a statement of your contract. Actual coverage is subject to terms and conditions specified in the benefit certificate itself and enrollment regulations in force when the benefit certificate becomes effective. Certain exclusions and limitations apply.

life insurance

Life Insurance Overview

The State offers two forms of group term life insurance - Basic and Supplemental; The Hartford underwrites both plans. The State of Iowa's Basic and Supplemental group life insurance is term life, meaning there is no cash value associated with the policy. Basic and Supplemental life insurance coverage amounts begin to decrease starting at age 65. Additional information about Basic and Supplemental life insurance is provided in the following sections and in the Life Insurance booklet certificate which is located at http://das.hre.iowa.gov/benefits/bene_lifeinsurance.html.

LIFE INSURANCE PREMIUMS

The State pays the entire premium for your Basic life insurance coverage. You can purchase Supplemental (additional) life insurance through payroll deduction. See your Personnel Assistant for premium information.

LIFE INSURANCE BENEFICIARY

Please be sure your beneficiary information is current. To change your beneficiary designation, see your Personnel Assistant for the current beneficiary change form.

Basic Life Insurance

If you work 30 or more hours a week and are under the age of 65, you are eligible for Basic group term life coverage in the amount of $20,000. The State pays the entire premium for basic coverage. You are automatically enrolled for basic coverage when you satisfy all eligibility requirements as defined in the group life booklet. Your life insurance coverage is generally effective the first of the month following 30 days of continuous employment.

Supplemental Life Insurance

You can obtain additional life insurance coverage by participating in the Supplemental Life Insurance plan. This plan allows you to purchase additional life insurance in $5,000 increments to a maximum of $50,000 ($30,000 for State Police Officers' Council employees; $40,000 for UE/IUP employees).

You can obtain any amount of Supplemental Life insurance coverage without providing evidence of insurability if you enroll within the first 30 days of employment. If you do not enroll for Supplemental Life insurance within 30 days of employment, you cannot apply for supplemental life coverage until the next annual enrollment and change period, unless you have a qualified life event. In either event, you will have to provide evidence of insurability to The Hartford and be approved for coverage by The Hartford before any increases become effective.

LIVING BENEFIT OPTION

If you are diagnosed with a terminal illness and have a life expectancy of 12 months or less, you may be able to have up to 75% of your life insurance benefits paid to you while you are still living. Proceeds can be paid in a lump sum or in monthly installments.

ACCIDENTAL DEATH AND DISMEMBERMENT

An amount equivalent to your Basic and Supplemental life coverage is provided for accidental death and a percentage of your basic and supplemental life coverage is provided for accidental dismemberment. Certain exclusions apply; consult your booklet certificate.

SEAT BELT BENEFIT

If an accidental death occurs while an employee is wearing a seat belt in the prescribed manner, the plan pays an additional benefit of 10% of the employee's coverage amount, up to $10,000.

AIR BAG BENEFIT

If an accidental death occurs while an employee is riding in an automobile seat equipped with an airbag system and wearing a seat belt, the plan pays an additional benefit of 10% of the employee's coverage amount, up to $10,000.

How to Make Changes

INCREASING COVERAGE

After your first 30 days of employment, you can only add coverage if you have a qualified life event, or during an annual enrollment and change period. Any increase to coverage requires that you provide evidence of insurability to The Hartford and be approved for the coverage by The Hartford. Contact your Personnel Assistant for an application for supplemental life insurance.

DECREASING COVERAGE

You can only decrease your life insurance coverage if you have a qualified life event, or during the annual enrollment and change period. If you decrease your coverage, and later decide to increase your coverage, you will only be able to increase your coverage during the annual enrollment and change period unless you have a qualified life event, and you will have to provide evidence of insurability to The Hartford. The Hartford will have to approve any additional coverage before it can become effective.

Contact your Personnel Assistant for the *Request to Decrease Supplemental Life Insurance* form.

BENEFICIARY CHANGES

You can change your life insurance beneficiary at any time. Your Personnel Assistant can provide you with the form you need to make a change. Changes to your beneficiary designation are not effective until received by your Personnel Assistant.

THINGS TO CONSIDER (ABOUT HOW MUCH INSURANCE TO PURCHASE)

- If you're trying to determine how much insurance to purchase, remember that this benefit is meant to help those who would suffer financially if you weren't there to help pay the bills.

Here are a few factors to consider:

- Mortgage, debts, food, clothes, and utility bills (the portion of these that are paid from your salary)
- Housekeeping bills (if you contribute to the running of the household by performing household tasks or running errands)
- Extra childcare expenses (to give your spouse some time off)
- Savings for children's education
- The cost of a funeral

HOW TO ENROLL IN SUPPLEMENTAL LIFE INSURANCE

Once you decide on the amount of supplemental life insurance that you need, see your Personnel Assistant for forms.

IMPUTED INCOME

If your total group life insurance coverage (basic and supplemental) is over $50,000 and you pay for supplemental life insurance on a pretax basis, you will have imputed income reported to the IRS. The value (determined by a cost table from the IRS) of the life insurance over $50,000 will be reported as imputed income and may be subject to taxes. The monthly value increases with age from $.05 per $1,000 of insurance for those under age 25 to $2.06 per $1,000 for those ages 70 and over.

CALCULATING IMPUTED INCOME AND LIFE INSURANCE PREMIUMS

Imputed income is calculated based on your age as of December 31 of the current calendar year. Imputed income is assessed by the number of $1,000 increments of coverage that are over $50,000. The IRS determines imputed income rates; rates by coverage level are provided in the following table.

Life insurance premiums are calculated based on your age at the beginning of the month. In the case of an individual who is between the ages of 40 and 44 years old, the 2009 monthly premium for $50.000 of supplemental coverage is $4.14, and imputed income is $2.00 for a total of $6.14 per month. The life insurance deduction would appear to be $6.14 per month. However, $2.00 of this amount is actually imputed income which is added to your taxable income. Then, the same amount ($2.00) is deducted from your net pay. The result is that you are taxed on the imputed income ($2.00). To see examples of how this would look on your electronic or paper pay stub, go to das.hre.iowa.gov/benefits/bene_lifeinsurance.html and click on the appropriate link.

For more information about your coverage, please see your State of Iowa Group Life Insurance booklet, ask your Personnel Assistant, visit the DAS Benefits Web site, or call The Hartford at 1-800-563-1124.

TOTAL LIFE INSURANCE COVERAGE MONTHLY IMPUTED INCOME*				
AGE	$55,000	$60,000	$65,000	$70,000
Under 25	$0.25	$0.50	$0.75	$1.00
25-29	$0.30	$0.60	$0.90	$1.20
30-34	$0.40	$0.80	$1.20	$1.60
35-39	$0.45	$0.90	$1.35	$1.80
40-44	$0.50	$1.00	$1.50	$2.00
45-49	$0.75	$1.50	$2.25	$3.00
50-54	$1.15	$2.30	$3.45	$4.60
55-59	$2.15	$4.30	$6.45	$8.60
60-64	$3.30	$6.60	$9.90	$13.20
65 & Over	N/A	N/A	N/A	N/A

*See your Personnel Assistant for monthly life insurance premiums.

long term disability insurance

Long Term Disability (LTD) Insurance Overview

(Employees working 30 or more hours per week)

The State provides Long Term Disability (LTD) coverage to all eligible full-time employees. If you have a disability that began on or after January 1, 2007, the LTD plan will cover 60 percent up to $60,000 of your annual pre-disability earnings. Disabilities that began prior to January 1, 2007 are covered at a lower level.

The plan provides monthly benefits if you have a disability that prevents you from performing those tasks required by your regular occupation. The Hartford underwrites the State's LTD plan. Additional information about the LTD plan is provided in the following sections. Detailed plan information is provided in the LTD booklet certificate, which is located at http://das.hre.iowa.gov/benefits/benefit_documents/Hd_ins_hartford_book.

LTD INSURANCE PREMIUMS

The State pays the entire premium for your LTD coverage. There is no option to purchase additional coverage. If you need to insure the remainder of your salary, you should investigate buying additional LTD coverage through your insurance agent or insurance company.

Please note that LTD benefits payable through other group plans will reduce your State of Iowa group LTD benefit payment.

ENROLLING FOR COVERAGE

You are automatically enrolled in the LTD plan when you satisfy all eligibility requirements as defined in the group LTD booklet. Your LTD coverage is generally effective the first of the month following 30 days of continuous employment.

GENERAL ASSEMBLY EMPLOYEES

If you are a part-time employee of the General Assembly you must pay for LTD insurance coverage. See your Personnel Assistant for more information.

LTD INSURANCE CARRIER

Group LTD insurance is provided by The Hartford.

LONG TERM DISABILITY BENEFITS

If you are approved for LTD benefits, they will begin on the first day following the "elimination period." The elimination period begins on your last day at work and continues through the later of 90 working days or the exhaustion of sick leave. Benefits will be paid if a disability prevents you from performing your regular occupation. An evaluation to determine continuation of benefits will occur 12 months from your last day at work. To continue to receive benefits after the initial 12 months, you must have a disability that prevents you from performing any gainful occupation or work for which you are or could become qualified for by training, education, or experience. Mental health and substance abuse disabilities are limited to 12 months. If you are approved for LTD, you may not receive donated leave.

Pre-existing conditions are not covered if the disability begins within 12 months of the date the coverage begins. A pre-existing condition is one for which you received medical treatment, consultation, care or services including diagnostic measure, took prescribed drugs or medicines, or followed treatment recommendations, or had symptoms for which an ordinarily prudent person would have consulted a health care provider, in the 12 months just prior to your effective date of coverage.

The LTD plan insures up to $60,000 of your annual salary. If you are approved for LTD, your benefits are calculated based on your pre-disability earnings (up to $60,000). The maximum monthly benefit is $3,000.

REHABILITATION REQUIREMENT

If The Hartford has come up with a rehabilitation plan for you which was approved by your doctor and you choose not to follow it, then your benefits will end.

RETURN TO WORK INCENTIVE

If you participate in a rehabilitation program offered by The Hartford, you may be able to receive additional benefits. See the LTD booklet certificate for more information about rehabilitation and return to work benefits.

SURVIVOR BENEFIT

When The Hartford receives proof that you have died, they will pay your eligible survivor (spouse, if living, otherwise, your children under age 25) a lump sum benefit equal to three months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate. The Hartford will first apply the survivor benefit to any overpayment that may exist on your claim.

CONTINUATION OF LIFE INSURANCE

If you are approved for LTD before you reach the age of 60, your basic and supple-mental life insurance continues, and your insurance premiums are waived. If you are over the age of 60 when you become disabled, you have up to 31 days from the date you cease active work to convert your life insurance to an individual policy. Supplemental Life Insurance premium payment must continue during the qualifying period for LTD.

RETURN TO WORK

If you are receiving LTD payments and return to any employment, whether it is with the State or not, you must contact The Hartford immediately to determine what impact your employment may have on your long term disability benefits.

WHEN BENEFITS END

If you are approved to receive LTD benefits, they will continue until the earlier of:

- you reach normal retirement age (unless age 61 or over on date of disability)
- your disability ends, or
- you fail to participate in a rehabilitation program, or
- you reach the maximum duration of benefits based on your age at the time your disability began.

Other terms and conditions may apply; consult the LTD booklet certificate.

long term disability insurance

THINGS TO CONSIDER ABOUT THE LTD PLAN

For disabilities that began **on or after** January 1, 2007, the maximum LTD benefit is $3,000 per month (60% of your salary; up to $5,000 per month or $60,000 a year). The maximum LTD benefit for disabilities that began **prior to** January 1, 2007 is $2,000 per month (60% of your pre-disability salary up to $3,333.33 per month or $40,000 per year).

Long term disability payments are reduced by any other income benefits such as benefits received from Workers' Compensation or Social Security Disability Income.

If you earn more than $60,000 per year, you may want to insure the remainder of your salary. You can investigate buying additional LTD coverage through your insurance agent or insurance company.

Please note that LTD benefits payable through other group plans will reduce your State of Iowa group LTD benefit payment.

The LTD plan does not cover any disabilities caused by:

- intentionally self-inflicted injuries
- active participation in a riot
- commission of a crime for which you have been convicted under state or federal law
- war, whether declared or undeclared

The plan also will not pay benefits during any period in which you are incarcerated as a result of a conviction.

For more information about your coverage, please see your State of Iowa Group Long Term Disability booklet, ask your Personnel Assistant, visit the DAS Benefits Web site, or call The Hartford at 1-800-752-9713.

LTD TERMS TO KNOW

Disabled You are disabled when The Hartford determines that:

- you are unable to perform the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to that sickness or injury.

After 12 months of benefits, you are disabled when The Hartford determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

Elimination Period The latter of the first 90 working days of any single period of Total Disability, or the date that the employee has exhausted all sick leave.

flexible spending accounts

WHAT ARE THEY?

Many employees pay for health and dependent care expenses on a regular basis. Did you know that the State of Iowa provides a way for you to save money on these expenses? Flexible Spending Accounts (FSAs) let you pay for certain health (through the Health FSA) and dependent care expenses (through the Dependent Care FSA) with tax-free dollars. This benefit saves you money by reducing your taxable income and increasing your spendable income. You contribute to one or both of the State's FSA accounts with pretax dollars and then are reimbursed for qualifying expenses for you and your family. Pretax dollars are not subject to state, federal, or FICA taxes.

The amount you designate for the year is divided into 24 equal amounts and held in your flexible spending account(s). When you submit receipts for eligible expenses, you draw your pretax money out of your FSA. You can choose to have payments mailed to you or deposited directly into your checking or savings account.

More information about this program is available on our Web site at: http://das.hre.iowa.gov/fsa/home.html or from Application Software, Inc. (ASI), the State's third party administrator. ASI can be reached at 1-800-659-3035 or www.asiflex.com.

How to Enroll

You may enroll within 30 days of hire or during the annual enrollment and change period. You must make a new election each year.

Coverage for new hires begins the month after you file your enrollment form. You may not submit claims for expenses incurred prior to your first month of coverage.

You must make a separate election for the Health FSA and the Dependent Care FSA. If you currently participate in one or both of the FSAs, you will automatically receive new enrollment forms from ASI, the State's FSA third party administrator.

When deciding how much to contribute to your account, estimate your expenses carefully. Once you enroll, you:

- will forfeit (use it or lose it) any unused account balance
- cannot change your contribution amount during the year unless you have a qualified employment or status change, such as marriage or divorce
- cannot be reimbursed through the Dependent Care FSA and claim a dependent care tax credit for the same expense
- cannot be reimbursed for a particular expense through the Health FSA and through any group or individual insurance
- cannot be reimbursed through the Health FSA and claim the same expense as a tax deduction
- cannot move funds from one FSA to the other

Please see your Personnel Assistant for the State of Iowa Enrollment Agreement Form or download a copy from the Iowa Department of Administrative Services Web site at: http://das.hre.iowa.gov/fsa/forms_documents.html.

How to Make Changes

In some situations, you may be able to change your FSA contribution levels. If you want to make a change, keep in mind that you must have a qualifying life event (see the Summary Plan Description for a list of events) and that **any change in election must be filed within 30 days of the event.**

If the change is approved by ASI, your change will become effective on the first day of the month following the submittal of a completed change form. Any increase in your election can include only those expenses that you expect to incur during the period of coverage subsequent to the effective date of the increase.

Childbirth and adoption bear special mention. You have 30 days from the birth or adoption of a child to enroll in or increase your Health FSA. If you have missed work due to the birth or adoption of a child, you have 30 days from return to work to enroll in or increase your Dependent Care FSA.

Health Flexible Spending Accounts

HOW DOES IT WORK?

When you incur an eligible medical expense, you complete a claim form, attach appropriate documentation and mail or fax it to ASI. You will receive payment from ASI by check or direct deposit, depending upon your election when you enroll. A medical expense is incurred when the services are provided that create the expense, not when you are billed for or pay for the service. You must receive the medical services before you file a claim for those services. You pay the medical bill directly, either at the time of service or later.

HOW MUCH CAN I CONTRIBUTE?

The maximum you are allowed to contribute to this FSA is $3,000 a year per participant. If your spouse is eligible to participate in a health flexible spending program, he or she may also contribute to his or her employer's plan. You cannot claim the same expense on both participants' plans.

WHAT IS AN ELIGIBLE EXPENSE?

You may submit expenses for yourself, your spouse, and your eligible dependents. An eligible dependent is defined by the Internal Revenue Service as a "qualifying child" or a "qualifying relative." Coverage of dependents under the Health FSA program is more restrictive than coverage for health or dental insurance. Coverage of adult children under the State's health or dental insurance plans does not mean that you are able to file FSA claims for that individual. The adult child must be considered a dependent as described in this paragraph to be eligible for claims reimbursement. For more information, see Internal Revenue Code section 152 or visit ASI's Web site at http://www.asiflex.com/faq/qualifying-dependent.htm.

Under certain circumstances, non-custodial parents may be eligible to submit claims for their dependents. Please contact ASI at 1-800-659-3035 for more information.

Some examples of items that may be eligible for reimbursement under the Health FSA if they are not covered by insurance are:

- Medical copayments and deductibles
- Prescription drug copayments
- Dental charges in excess of insurance coverage
- Eye glasses and contact lenses
- Hearing aids
- Over-the-counter medicine used to treat a medical condition
- Medically necessary weight loss programs as prescribed by a physician (health club dues and special foods do not qualify)

A complete list of eligible expenses is available in Internal Revenue Service Publication 502. However, insurance premiums and long term care expenses are not eligible even though they are mentioned in IRS Publication 502.

Expenses must be incurred during your period of coverage. The following are not eligible expenses:

- Products advertised, marketed, or offered as long-term care insurance
- Medical savings accounts under section 106 (b)

WHEN CAN I INCUR EXPENSES?

Participants may incur claims through March 15 after the plan year. For example, a participant may buy eye glasses on March 1, 2010 and be reimbursed out of funds contributed in 2009.

Any reimbursement for claims with service dates of January 1, 2010 to March 15, 2010 will be applied to 2009 available funds, if any, with the remainder applied to 2010 funds.

All claims must be postmarked by April 15 each year, or by the next business day if April 15 falls on a weekend. Any funds not claimed timely will be forfeited.

WHAT HAPPENS WHEN I LEAVE STATE EMPLOYMENT?

If you leave State employment and are enrolled in the Health FSA, you may be able to continue participating in the Health FSA if you meet certain requirements. Continuation of coverage will be provided if, on the date of the qualifying event, your remaining benefits for the current plan year are greater than your remaining program contribution payments.

Qualifying life events include termination of employment, death, divorce, or dependent loss of eligibility. You must notify the plan administrator if any of these events, other than termination of employment, apply to you.

Your right to elect to continue coverage ends 60 days from the date on the continuation notice provided by the third party administrator. If continuation is elected, the remaining program contributions will be charged to you, your spouse, or dependent, as the case may be, for any period of continuation coverage at 102% of the cost of providing coverage for the period to similarly situated participants, spouses, or dependents.

Continuation will only be extended to the end of the current plan year but may terminate sooner if the premiums described above are not paid within 30 days of the due date.

If you meet the eligibility criteria for continued participation in the Health FSA, you will be notified by ASI. If you elect to continue participation, you must pay your contributions plus a 2% administration fee.

Dependent Care Flexible Spending Accounts

HOW DOES IT WORK?

When you incur an eligible dependent care expense, complete a claim form, attach appropriate documentation, and mail or fax it to ASI. You will receive payment from ASI by check or direct deposit, depending upon the payment election you make when you enroll. A dependent care expense is incurred when the services are provided that create the expense, not when you are billed for or pay for the service. You will only receive reimbursement for the amount that you have contributed through payroll deduction.

HOW MUCH CAN I CONTRIBUTE?

Dependent Care FSA maximum contribution amounts depend on whether you are single or married and on your tax filing status. You cannot contribute more than your or your spouse's earned income. The maximum contribution amounts are:

- $5,000 if you are single, or married and file a joint return
- $2,500 if you are married and file separate returns
- $5,000 combined maximum if your spouse also contributes to a dependent care account
- $3,000 if your spouse is a full-time student and you have one dependent
- $5,000 if your spouse is a full-time student and you have more than one dependent

WHEN CAN I INCUR EXPENSES?

All expenses must be incurred by March 15th after the plan year. For example, a participant may incur a day care claim in February of 2010 and be reimbursed out of funds contributed in 2009. All claims must be postmarked by April 15 of each year, or the next business day if April 15 falls on a weekend. Any funds not timely claimed will be forfeited.

Any reimbursement for claims with service dates of January 1, 2010 to March 15, 2010 will be applied to 2009 available funds, if any, with the remainder applied to 2010 funds.

WHAT IS AN ELIGIBLE EXPENSE?

Each year, you can set aside pretax dollars to cover expenses for dependents if:

- They are under age 13; or
- They are mentally or physically incapable of self-care and reside in your home at least eight hours a day, regardless of age; and
- You claim them as dependents for federal income tax purposes.

If you are married, to be eligible your spouse must either:

- Be a full-time student;
- Work; or
- Be incapable of self-care.

In addition:

- Expenses must be for care that enables both spouses to work; and
- If your spouse works, his or her income must be greater than the reimbursement of dependent care expenses.

You are not eligible for dependent care participation during periods in which you are not at work. If you are on leave, including workers' compensation or maternity leave, you are not eligible to participate and cannot receive reimbursement for expenses incurred during your leave period.

Eligible expenses include:

- In-home day care
- Day care at someone's house
- Nursery school
- Adult day care (dependent must live in home for at least eight hours a day)
- Boarding school (the portion of the cost used for care of the dependent under age 13)
- Dependent care centers (that comply with state and local laws and licensing requirements)
- Household services (if the dependent is being cared for in the home and the household services are necessary for the dependent's care)
- Preschool
- Summer day camp (if the child does not stay overnight), but not instructional camps

The following are not eligible expenses:

- qualified scholarships under section 117
- educational assistance programs under section 127
- fringe benefits under section 132
- transportation expenses

WHAT HAPPENS WHEN I LEAVE STATE EMPLOYMENT?

If you terminate employment, you may continue to file claims for qualifying expenses incurred during the calendar year until you have been reimbursed the balance in your account. Qualifying expenses include those incurred while you are employed by another employer or are actively looking for work.

You cannot participate in the Dependent Care FSA and be eligible for the dependent care tax credit. Before enrolling in the Dependent Care FSA, you should consult your tax advisor to see if it may be advantageous to take the dependent care tax credit.

Program Basics

EXPLANATION OF BENEFIT

The Retirement Investors' Club(RIC) (also referred to as deferred compensation) is a voluntary retirement savings program designed to increase your personal long-term savings. Your contributions are invested on a pretax basis. Contributions and earnings are not taxed until you take the money out as income. RIC contains two plans, the 457 Employee Contribution Plan and the 401(a) Employer Match Plan. You are fully invested in both plans from day one. For more detailed information, visit our Web site at http://das.hre.iowa.gov/ric.html.

ELIGIBILITY

You are eligible to contribute if you are a permanent or probationary employee of the State of Iowa working 20 or more hours per week or an employee who has a fixed annual salary. This program is not offered to Board of Regents Institution employees.

ENROLLMENT*

The first step to enrollment is choosing your investment provider. Your provider has all the investment information and forms you need to open your account. You may access provider and product information online or call one of the following numbers.

The approved providers are:

AIG Retirement
1-800-945-6763
www.aigretirement.com/iowa

Hartford Life
1-866-301-2647
www.retire.hartfordlife.com/iowa/

ING Financial Advisers
1-800-555-1970
http://www.ingretirementplans.com/SponsorExtranet/Iowa/

Nationwide Retirement Solutions
1-877-677-3678
www.nationwideiowadc.com

HOW MUCH CAN I CONTRIBUTE?

Your contributions are taken from your paycheck before state and federal income taxes and deposited in your designated investment selections. You may choose to contribute as little as $25/month ($12.50 per pay period) or as much as $16,500 (regular limit), $22,000 (50+ Catch-Up), or $33,000 (3-Year Catch-Up).

Before you retire, consider the option of deferring your unused vacation pay and sick pay to your deferred compensation account.

You may elect to roll assets from your previous government employer's 457 plan into your 457 account at the State. You may also roll your previous 401(k), 401(a), 403(b), 403(a), IRA (traditional or rollover), or SEP into your State 401(a) employer match account.

Please Note: The total of all contributions made to this 457 plan and/or any other government employer's eligible 457 plan must not exceed the IRS annual maximum limits.

*Enrollment is always open

deferred compensation program

WILL I RECEIVE AN EMPLOYER MATCH?

The State is offering a match to participants' 457 plan contributions. This match does not reduce the maximum contribution limit in your 457 account. The State will match $1 for every $2 you contribute to the 457 plan, up to the monthly maximum match amount of $75.

WHAT ARE MY INVESTMENT OPTIONS?

Each active provider (AIG Retirement, Hartford Life, ING Financial Advisers, Nationwide Retirement Solutions) has many investment options ranging from conservative to aggressive. You have the option of choosing one or several investments including fixed rate accounts, mutual funds and variable annuities. Your investment selection should be based on your goals for your retirement savings, your risk tolerance, and the length of time you have to invest. These active providers offer you the option of changing your investment selections at any time.

HOW DO I GET MY MONEY OUT?

You do not have the option to receive a distribution from your RIC accounts while you are employed except in the case of an approved hardship withdrawal, cash out, or an IPERS service credit purchase. Hardship withdrawals are only approved in rare circumstances, such as a significant loss of income or unexpected medical expenses that are not covered by insurance. RIC does not have a loan provision.

Once you terminate from employment, you are eligible to take distributions from your RIC accounts.

If you are invested with one of the following providers, you do not need to contact the Department of Administrative Services. You may request a distribution directly from your active provider at the numbers listed.

AIG Retirement	**1-800-945-6763** **(515) 267-1099 in Des Moines**
AXA Equitable	**1-877-800-7279 option 3** **(515) 225-1141 in Des Moines**
Hartford Life	**1-800-528-9009**
ING Financial Advisers	**1-800-555-1970** **(515) 698-7973 in Des Moines**
Nationwide Retirement Solutions	**1-877-677-3678**

If you are invested with any provider other than the five listed above, please complete the *State Distribution Form for Inactive Providers* and call your provider to confirm whether or not you are also required to complete a provider distribution form.

WHAT ARE MY OPTIONS WHEN I RETIRE?

Before you retire, consider the option of deferring your unused vacation pay and sick pay to your RIC account.

1. **Leave your assets fully invested** in RIC and defer paying taxes until age 70½, at which time you must begin taking at least the required minimum distributions annually. If you leave your assets in RIC, you have the option of changing your investment selections and/or provider at any time (some product restrictions may apply). Your 457 Employee Contribution Account is not subject to a 10% early withdrawal penalty by the IRS.

2. **Take income** in one of the following ways (some product restrictions may apply).
   - Total lump sum distribution
   - Partial lump sum distributions
   - Systematic/periodic payments
   - Lifetime payments

   For tax information on distributions, see the Special Tax Notice attached to your distribution form. Be sure to check with your provider for possible surrender charges.

3. **Roll over** all or a portion of your assets to a 457, 401(k), 401(a), 403(b), 403(a), IRA (traditional or rollover), or SEP. If eligible, you may purchase IPERS service credit with your funds. This is a non-taxable event. Once you roll your 457 employee contribution assets to a qualified plan or IRA, you may be subject to a 10% penalty by the IRS if you take distribution from the new plan before age 59½.

additional employee benefits

Employee Assistance Program (EAP)

WHAT IS THE EMPLOYEE ASSISTANCE PROGRAM (EAP)?

The Employee Assistance Program (EAP) provides confidential, professional assistance to employees and family members of employees of the Executive, Legislative and Judicial Branches of state government. EAP services are provided by Employee & Family Resources (EFR), a private agency under contract with the state, and include assessment, short-term counseling, and referral to appropriate community agencies.

EAP counselors are not state employees. Calls to EAP counselors are confidential within strict legal limits. They will not tell anyone you called or release any information without your written permission unless a legal exception applies. Legal exceptions include child or dependent adult abuse or neglect or life threatening situations.

WHAT TYPES OF SERVICES DOES EAP PROVIDE?

Counseling Services

EAP counseling services are intended to help people before problems interfere with job performance. Problems for which the EAP counselors can provide help include:

- Alcohol or other drug abuse
- Marriage or family problems
- Financial consultation (budgeting, investing)
- Health or stress concerns
- Career struggles/job burn-out
- Death/dying issues
- Interpersonal conflicts
- Workplace conflicts
- Legal concerns (personal, non-employment related)

Appointments with EAP counselors are available some evening and weekend hours, as well as during business hours. You may see a counselor on your own time and no one will need to know. If you need to see an EAP counselor during work time, you will need to:

- Get approval from your supervisor for time away from work.
- Sign a release of information form provided by the EAP counselor. This allows the counselor to confirm your work time attendance with your supervisor. No other information will be released without your written permission.

Life Coaching Services

Life Coaching services are intended to help you and your family members resolve life issues. Coaching services provide a trained life coach, a personal, secure Web site, scheduled telephone sessions with your life coach, and the ability to communicate with your life coach through your personal Web site.

A few examples of the areas where life coaching might be of help to you include:

- Family Issues
- Caring for a Dependent Adult
- Couple/Marital Relationships
- Grief/Loss
- Weight Management
- Smoking Cessation
- Work/Life Balance

These are just a few examples of the types of situations where life coaching might be a good alternative to in-person counseling.

Of course, the choice is yours. You can still have face-to-face contact with a counselor if you prefer. Life Coaching services are offered **as an alternative** to the in-person assessment and brief counseling services that are currently offered.

HOW MUCH WILL IT COST (TO GO TO EAP)?

There is no charge to you for services provided by the EAP. However, EAP services are intended to be short-term in nature. Life coaching services are generally provided for up to nine weeks.

Counseling services are limited to three (3) sessions with an EAP counselor per incident. If an EAP counselor refers you to other resources for additional help, those resources may charge for their services. EAP counselors will work with you to identify resources that are affordable or that may be partially covered by your health insurance. If you have questions about whether you are covered by the EAP, contact your Personnel Assistant or District Court Administrator.

CONTACT THE EAP
(515) 244-6090 (Des Moines area)
1-800-EAP-IOWA (or 1-800-327-4692)
Outside of Iowa: 1-800-327-3020
Or visit EFR's Web site at:
www.efr.org/eap/your_eap/login.php.

Workers' Compensation

If you are injured on the job as a result of your employment, you may be eligible for Workers' Compensation benefits. Workers' Compensation benefits are provided to you by law and do not require any action by you to obtain coverage. Under Workers' Compensation, you may be eligible for wage replacement and medical care. If you sustain an injury or illness that you believe is work-related, you must notify your employer, who will ask that you complete a first report of injury. Your supervisor or Personnel Assistant can help you with this process.

Your first report of injury will be sent to Sedgwick Claims Management Services (Sedgwick CMS) for evaluation and handling. Sedgwick CMS, a national third party administrator in the area of Workers' Compensation, assumed responsibility for the State of Iowa Workers' Compensation claims on July 1, 2001. They are responsible for claims intake, evaluation, direction of medical care, benefits payment, and all other aspects of the day-to-day handling of Workers' Compensation claims filed by State of Iowa employees.

If your Workers' Compensation claim is approved by Sedgwick CMS, every effort will be made to assist you in returning to work. When available, you will be given a restricted duty assignment until you recover enough to return to your regular job. Your job class and rate of pay will not be reduced while you are performing your restricted duty job. If you refuse to accept a temporary restricted duty assignment, your Workers' Compensation benefits may be suspended. The original period of restricted duty is the hourly equivalent of 20 workdays (pro-rated for part-time employees), or until you are medically released to full duty, whichever is less. In certain cases, extensions may be granted.

If your claim is denied by Sedgwick CMS, a letter will be sent directly to you. This letter should be presented to your group health carrier if they deny medical coverage based on the Workers' Compensation filing. The Iowa Department of Administrative Services is responsible for the management of the program and the contractual agreement with Sedgwick CMS.

All communication and correspondence regarding Workers' Compensation claims to Sedgwick CMS should be directed to:

Sedgwick CMS
P.O. Box 14628
Lexington, KY 40512
Phone: (515) 327-4888
Fax: (515) 327-4899
Toll Free: 1-866-342-3920
After Hours New Report Call Center: 1-866-222-8768

Employee Discount Program

State of Iowa employees can save money on purchases with discounts on computers, cell phones, hotels, flowers, jewelry, clothing, gifts, restaurants, and more! You'll find valuable offers from your favorite merchants, including Apple, Target, Costco, Disney World, Dell, Verizon, and AMC Theaters. You'll also find discounts from local and statewide businesses.

The Employee Discount Program is administered by PerkSpot, a company that manages employee discount programs for a variety of employers.

Eligibility requirements are set forth by the discount vendor and generally include all permanent state employees. Employees must contact the vendor for any specific questions or concerns and for all customer service functions. Employees and vendors can email comments or suggestions to PerkSpot.

TO GET DISCOUNTS

To take advantage of the Employee Discount Program, create an account with PerkSpot using your personal email address at http://iowa.perkspot.com. Enter in the company code "Iowa". You will then receive a confirmation email with login instructions.

After you have created your account you can log in at http://iowa.perkspot.com to see all discount offers available to State of Iowa employees. Most discounts at this time are for on-line purchases only, but as the program evolves and more discounts are added, more on-site discounts may become available. If the discount is accessible online, the vendor should provide a special access code to you.

Vendors' requirements for you to receive discounts may vary and can include coupons, flyers, and/or presentation of your State of Iowa Employee ID card. Employees must contact the discount vendor for any proof of employment requirements, typically a pay stub or state ID. Some vendors may include retirees in their offers. If you do not have any identification at the time of purchase, the vendor may not honor the discount.

If you experience any difficulties with any discount or service, please contact PerkSpot by sending an email to help@perkspot.com.

continuing insurance coverage
upon termination of state employment

COBRA

HEALTH AND DENTAL INSURANCE

If you leave state employment, the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provides for continuation of health and dental benefits coverage at the group premium rate after your coverage with the State ends. However, certain events must occur for any persons covered under your contract to be eligible (see events below).

The State's share of the premium payment for health and dental benefits will cease at the end of the month in which the qualifying events occurs, and you will be responsible for full payment of the premium. COBRA coverage begins the first of the month following the qualifying event. The COBRA election period is 60 days after the later of:

- the date coverage would otherwise end, or
- the date of the *COBRA Notification/Election Form*.

If your employment ends, the Iowa Department of Administrative Services will mail a *COBRA Notification/ Election Form* to you within two weeks following your last paycheck. The notification includes monthly benefit costs and election instructions. In the event of the death of an active employee, the family will receive notice of their COBRA rights. If an employee divorces, reduces hours, or has a dependent that is no longer eligible for coverage, the employee must notify his or her Personnel Assistant within 60 days following the event so that the personnel assistant can send the COBRA information.

PLEASE NOTE:

COBRA rights will not be extended to a Domestic Partner or his/her children, if the relationship terminates, if the employee terminates from State employment, or if the domestic partner's children have an event that makes them ineligible for employee's plan.

You can see a copy of the *General Notice of COBRA Continuation Coverage Rights* at http://das.hre.iowa.gov/benefits.html.

EVENT:	MAXIMUM ELIGIBILITY PERIOD BEYOND TERMINATION
Employee Termination/ Resignation	The employee and covered dependents have 18 months of COBRA eligibility. If the employee meets the Social Security Administration's definition of disabled at any time during the first 60 days of COBRA coverage, the employee and covered dependents have 29 months of COBRA eligibility.
Death or Divorce of Employee	The covered dependents have 36 months of COBRA eligibility.
Employee Reduces Work Hours; No Longer Eligible	The employee and covered dependents have 18 months of COBRA eligibility.
Employee's Dependent No Longer Eligible (Age 19 to 25 and no longer a full-time student, marries, or no longer resides in the State of Iowa)	The covered dependent has 36 months of COBRA eligibility.
Employee on Active Military Duty	The employee and covered dependents have 24 months of COBRA eligibility.

continuing insurance coverage upon termination of state employment

Life Insurance

When you leave State employment, your State-sponsored life insurance coverage ends. Depending on the reason you are leaving, you may have more than one option for continuing your life insurance coverage at your own expense.

PORTABILITY

If you leave State employment for reasons other than disability or retirement, you may be able to continue your Supplemental Life and Supplemental AD&D insurance through a portability provision. This provision is available if you have $20,000 or more of Supplemental Life coverage, are under age 70, and are actively at work on the day before your employment ends. Your Personnel Assistant will complete the employer section of the *Life Insurance Portability Form*; you are then responsible for contacting The Hartford and submitting any required information to them. Once you receive this information, it is your responsibility to contact the insurance carrier, and any resulting coverage is provided under the terms of the group portability contract.

CONVERSION

If you have less than $20,000 of Supplemental Life insurance you can elect to convert your group term life insurance to an individual whole life policy through the life insurance carrier, currently The Hartford. Your Personnel Assistant can provide you with the forms and information that you will need to convert your life insurance. Once you receive this information, it is your responsibility to contact the insurance carrier, and any resulting coverage becomes an individual contract between you and the insurance carrier.

Termination Due To Approval for Long Term Disability

HEALTH AND DENTAL INSURANCE

If you terminate employment upon approval for Long Term Disability (LTD), in lieu of COBRA coverage, you are allowed to continue your coverage with the State group for as long as you remain disabled according to the plan definition of disability. The State's share of the monthly premium will cease at the end of the month in which your employment terminates. LTD coverage will begin the first of the month following termination and you will pay the full monthly premium for any insurance coverage you choose to keep.

You may drop your State group plan completely. However, there is currently no provision for rejoining the group at a later date.

If you continue your insurance coverage with the State of Iowa group, you will be able to participate in the annual enrollment and change period, which will allow you to change your health plan every year. You can continue your group health and group dental coverage separately or together. You do not have to elect to continue in both plans. Your benefits as a member of the Retired/Disabled group are identical to benefits for the plan you held as an active employee.

If the LTD carrier determines that you are no longer eligible for LTD benefits and you are not drawing a retirement benefit, health and dental benefits will stop. You will need to purchase individual health and/or dental coverage at that time.

You can continue your coverage with the group if you become eligible for Medicare. It is your responsibility to submit proof that you have

continuing insurance coverage upon termination of state employment

Medicare Parts A and B to your health insurance carrier. Medicare will become the primary payor on claims and the State group will pay as secondary. A premium rate reduction will occur at that time.

In addition to Parts A and B of Medicare, you may enroll in **SilverScript**, a Medicare Part D Prescription Drug Plan. Enrolling in SilverScript is voluntary. However, enrolling will reduce your monthly retiree premium because SilverScript will coordinate on drug cost with your Wellmark plan. Your prescription drug benefits will not change. You will continue to have the same drug plan that you had as an active employee. However, SilverScript will pay on your prescriptions as primary and the State's group will become secondary. There is a separate monthly premium for SilverScript. For more information, or to enroll, contact SilverScript at 1-866-808-7475.

Generally, Medicare eligibility is granted when you turn age 65. It can also be granted at an earlier age if you have a disability. Once you become Medicare eligible, you may elect to drop the State group coverage and purchase a private Medicare Supplement Policy. A Medicare Supplement Policy differs from the State group in that the benefits provided vary by supplement option. If you continue with the State group plan after you become eligible for Medicare, your benefits do not change. Benefits offered to Medicare eligible persons are the same as the benefit plan offered prior to becoming Medicare eligible.

Employees must see their Personnel Assistant for specifics and the required paperwork at the time of termination of employment.

LIFE INSURANCE-UNDER AGE 60

If you are under age 60 when you are approved for Long Term Disability (LTD), your life insurance automatically continues in the same amount that you maintained while you were working. You will not have to pay premiums for your coverage as long as you continue to be disabled according to the State's LTD insurance carrier. The insurance is subject to the normal age reductions of coverage in your group contract. Your group life insurance will end when you are no longer disabled according to the group definition of disability or until you reach age 70, whichever occurs first.

If your Long Term disability coverage ends, your life insurance coverage also ends. You can elect to convert your group term life insurance to an individual whole life policy through the life insurance carrier. Your Personnel Assistant can provide you with the forms and information that you will need to convert your life insurance.

LIFE INSURANCE-OVER AGE 60

If you are age 60 or older on your date of disability (last active day at work), you can convert your group life insurance to an individual whole life insurance policy. This conversion privilege will be offered when a decision is reached on your claim or your employment terminates, whichever occurs first. You must apply within 31 days from the end of the month in which you are notified in writing of your conversion rights. Monthly premiums must be paid continuously prior to the notice. Contact your department's Personnel Assistant for the ***Life Conversion Form***.

continuing insurance coverage
upon retirement

HEALTH AND DENTAL INSURANCE

(Excludes employees covered by the State Police Officers' Council)

When you retire, you can continue to participate in the State of Iowa group health and dental plans for life. Coverage in the active employee group will cease at the end of the month in which you retire. Your coverage as a retiree will begin the first of the month following retirement.

You may drop your State group plan completely. However, there is currently no provision for rejoining the group at a later date. As a retiree, you will be able to participate in the annual enrollment and change period, which will allow you to change your health plan every year. You can continue your group health and group dental coverage separately or together. You do not have to elect to continue in both plans. Your benefits as a retiree are identical to benefits for the plan you held as an active employee.

You can continue your coverage with the group if you become eligible for Medicare. It is your responsibility to submit proof that you have Medicare Parts A and B to your health insurance carrier. Medicare will become the primary payor on claims and the State group will pay as secondary. A premium rate reduction will occur at that time.

In addition to Parts A and B of Medicare you may enroll in **SilverScript**, a Medicare Part D Prescription Drug Plan. Enrolling in SilverScript is voluntary. However, enrolling will reduce your monthly retiree premium because SilverScript will coordinate on drug cost with your Wellmark plan. Your prescription drug benefits will not change. You will continue to have the same drug plan that you had as an active employee. However, SilverScript will pay on your prescriptions as primary and the State's group will become secondary. There is a separate monthly premium for SilverScript. For more information or to enroll, contact SilverScript at 1-866-808-7475.

The State of Iowa has determined that your prescription drug coverage with the state's health care plans is as good as or better than the standard Medicare prescription drug coverage (Part D). This means that your State of Iowa coverage is considered "creditable coverage" and that you will not pay extra if you later decide to enroll in Medicare prescription drug coverage. Please review the *Notice of Creditable Coverage* on the DAS benefits Web page for Medicare-eligible retirees or see your Personnel Assistant for a copy.

Generally, Medicare eligibility is granted when you turn age 65. It can also be granted at an earlier age if you have a disability. Once you become Medicare eligible, you may elect to drop the State group coverage and purchase a private Medicare Supplement Policy. A Medicare Supplement Policy differs from the State group in that the benefits provided vary by supplement option. If you continue with the State group plan after you become eligible for Medicare, your benefits do not change. Benefits offered to Medicare eligible retirees are the same as the benefit plan offered prior to becoming Medicare eligible.

A retiree's surviving spouse, if covered at the time of the former employee's death, is allowed lifetime coverage with our State of Iowa group health and dental plans.

Employees must see their Personnel Assistant for specifics and the required paperwork at the time of retirement.

LIFE INSURANCE

When you retire, your State-sponsored life insurance coverage ends. You can elect to convert your group term life insurance to an individual whole life policy through the life insurance carrier, currently The Hartford. Your Personnel Assistant can provide you with the forms and information that you will need to convert your life insurance. Once you receive this information, it is your responsibility to contact the insurance carrier, and any resulting coverage becomes an individual contract between you and the insurance carrier.

continuing insurance coverage upon retirement

SICK LEAVE INSURANCE PROGRAM

If you are an AFSCME, UE/IUP, or Non-Contract covered employee in the Executive Branch and are eligible for a bona fide retirement, you may participate in the Sick Leave Insurance Upon Retirement Program (SLIP). This program allows you to convert your unused sick leave into a bank to be used toward the purchase of the State's health insurance plan after retirement and until you are eligible for Medicare.

This program does not include elected officials, employees in the Judicial or Legislative branch, Board of Regents employees, or SPOC-covered employees. Those groups may be eligible for similar programs that are designed just for them. This program is for health insurance only. It can not be used for dental insurance or any health insurance program except the plans offered in the State of Iowa Employee's Group Insurance Plan.

Upon a bona fide retirement, defined as applying for and receiving monthly state pension benefits, you will receive cash payment for up to $2,000 of your unused sick leave. This payment will be made on your final pay check. Any remaining balance shall be converted and paid as follows upon a bona fide retirement:

Sick Leave Balance	Conversion Rate
0 to 750 hours	60% of value
over 750 to 1,500 hours	80% of value
over 1,500 hours	100% of value

The value of the sick leave bank is calculated as follows:

- identify the total number of hours in the sick leave bank on the last day of work
- multiply the total sick leave balance times the regular hourly pay
- subtract the $2,000 sick leave payment
- multiply the remaining amount times the conversion rate

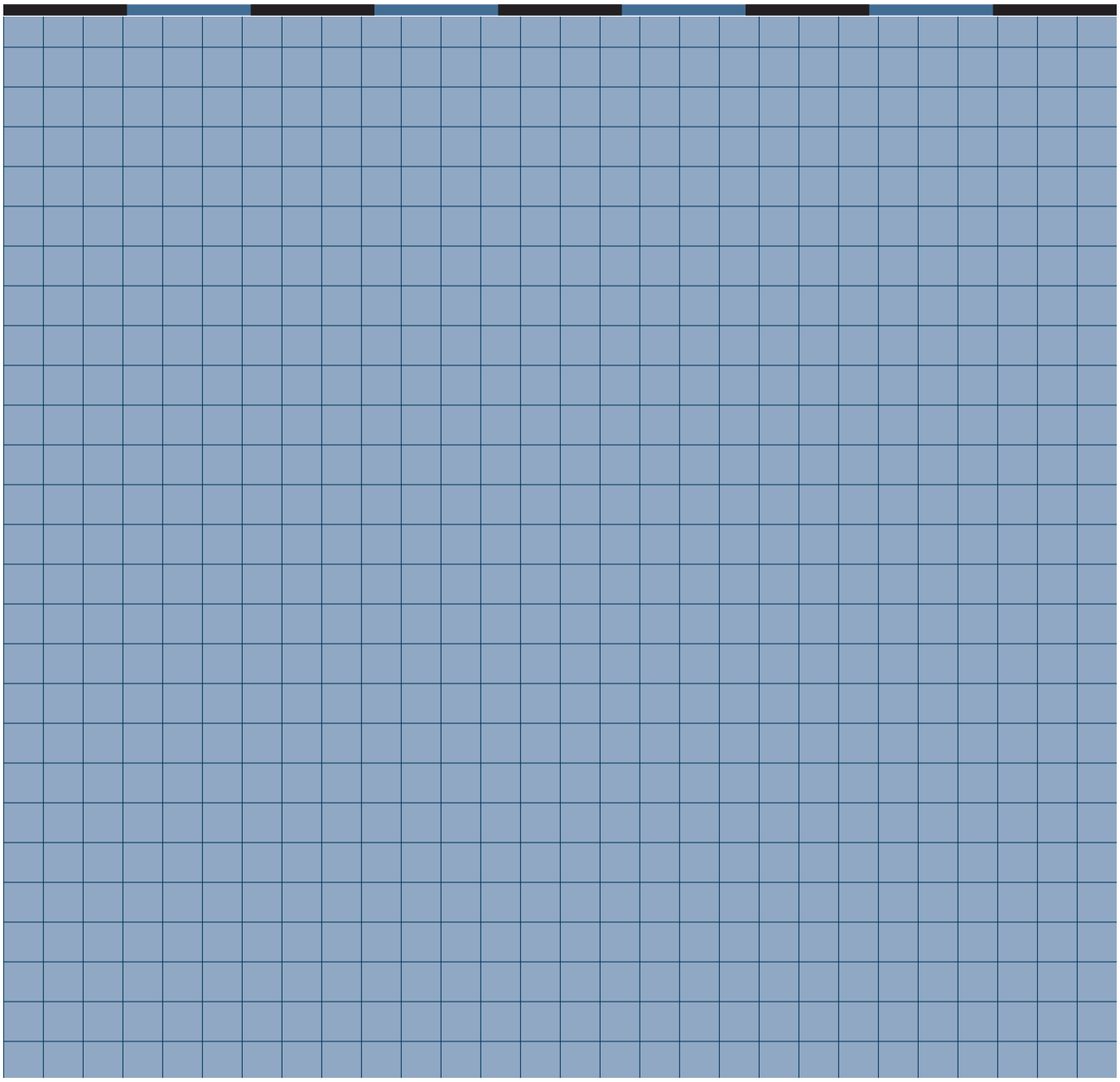
The result is your sick leave account balance.

The State will pay its share of the monthly premium from this account until one of the following occurs:

- you cease participation in the State's group insurance program
- the account is exhausted
- you fail to pay any undue share of the premium due, if necessary
- you become Medicare eligible
- you return to permanent employment with the State of Iowa
- you die

When the sick leave account is exhausted or you become eligible for Medicare, you may still continue coverage with the State's group plan. You would then begin paying the appropriate monthly premium without any State contribution.

For more information, visit the SLIP Web site at http://das.hre.iowa.gov/benefits/benefit_pages/bene_slip.html.



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